Supreme Court, U.S.
FILED

No. 02- 27 JUN 27 2002

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In The
Supreme Court of the United States

ALLINA HEALTH SYSTEM CORP., ET AL.,

Petitioners,

v.

UNITED STATES OF AMERICA, EX REL.
MINNESOTA ASSOCIATION OF
NURSE ANESTHETISTS,

Respondent.

**On Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Eighth Circuit**

**APPENDIX
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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

UNITED STATES OF AMERICA, ex rel MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS,	*	Civil Action File No. 4-96-734
v.	*	
ALLINA HEALTH SYSTEM CORP., UNITY HOSPITAL, MERCY HOSPITAL, JOHN MURPHY, MIDWEST ANESTHESIOLOGISTS, P.A., METROPOLITAN ANESTHESIA NETWORK, ALLEN TANK, HEALTH BILLING SYSTEMS, INC., THELMA M. ALBAY, M.D., GARY BAGGENSTOSS, M.D., MINDA CASTILLEJOS, M.D., DAVID CUMMING, M.D., TERI HEIL, M.D., SANG HONG, M.D., TED JANOSSY, M.D., RAYMOND KLOEPPER, II, M.D., JOHN MAGDSICK, M.D., THOMAS MAGGS, M.D., THOMAS POLTA, M.D., JOHN ROSEBERG, M.D., JAI SUH, M.D., MARK SPERRY, M.D., JEFFREY YUE, M.D., and JOHN RYDBERG, M.D., ST. CLOUD HOSPITAL, ANESTHESIA ASSOCIATES OF ST. CLOUD LTD., GARY A. BOEKE, M.D., PHILIP F. BOYLE, M.D., L. MICHAEL ESPELAND, M.D., ALAN D. ESPELIEN, M.D., PAUL J. HALVERSON, M.D., CRAIG JOHNSON, M.D., LANSE C. LANG, M.D., A. WADE McMILLAN, M.D., WILLIAM H. RICE, M.D., ALLAN REITZ, M.D., ANNETTE E.	*	THIRD AMENDED COMPLAINT

ZWICK, M.D., ANESTHESIOLOGY, P.A., ABBOTT NORTHWESTERN HOSPITAL, NORTHWEST ANESTHESIA, P.A., BRYCE BEVERLIN, M.D., RICHARD BLOMBERG, M.D., JEAN BOENING, M.D., MITCHELL BURKE, M.D., RAJARAO DWARAKANATH, M.D., RICHARD ENGWALL, M.D., JAMES GAYES, M.D., LUIS GIRON, M.D., NANCY GROVES, M.D., JONATHAN GUDMAN, M.D., RICHARD JOHNSON, M.D., JOHN LILLEHEI, M.D., ROBERT McKLVEEN, M.D., JUDITH MEISNER, M.D., MICHAEL MENZEL, M.D., JAMES MUSICH, M.D., MARK NISSEN, M.D., XAVIER PEREIRA, M.D., DAVID PLUT, M.D., JEFFREY SHAW, M.D., RICHARD SKOOG, M.D., WILLIAM STAUFFER, M.D., OFELIO TIU, M.D., ROBERT TRONNIER, M.D., JOHN WINTERMUTE, M.D., and [other unknown defendants], Does I through XX

Defendants.

****

Plaintiffs as and for their Third Amended complaint against defendants say:

JURISDICTION AND VENUE

1. This is an action to recover damages and civil penalties on behalf of the United States of America arising out of false and/or fraudulent claims presented by Defendants under the Federal Medicare Program. This action

arises under the provisions of Title 31 U.S.C. Section 3729, *et seq.* popularly known as the False Claims Act which provides that the United States District Courts shall have exclusive jurisdiction of actions brought under that Act.

2. Under Section 3732(A), venue is proper in this District because defendants reside in this District and the acts complained of herein occurred in the State of Minnesota, within this judicial district.

PARTIES TO THE ACTION

3. *Qui tam* Plaintiff Minnesota Association of Nurse Anesthetists ("MANA") is an association formed for the purpose of preserving and advancing the profession of Certified Registered Nurse Anesthetists ("CRNAs") in Minnesota and to engage in activities to promote and protect the legal rights of its members through, among other things, lobbying efforts, legal action and public relations activities. MANA has standing to bring this complaint for itself and on behalf of the United States Government pursuant to 31 U.S.C. § 3730. Various of MANA's members were employed by defendant hospitals at times relevant to this complaint. Hereafter, MANA will alternatively be referred to as "Relator."

4. Under the Act, the Complaint must be filed *in camera* and remain under seal for a period of at least sixty (60) days and shall not be served on the Defendant until the Court so orders. The Government may elect to intervene and proceed with the action in sixty (60) days after it receives both the Complaint and the material evidence and information or to authorize the Relator to prosecute the action on the Government's behalf. Plaintiffs have complied with these provisions.

5. On May 17, 1995, the Government requested the Court to unseal this action and authorized MANA to pursue the action in the name of the United States. The Court unsealed the action by Order dated May 23, 1995. Since that time the Government has monitored the action and reviewed copies of discover, motions and pleadings in the case.

6. As required under the False Claims Act, 31 U.S.C. § 3730 (a) (2), Relator has provided to the Attorney General of the United States and to the United States Attorney for the District of Minnesota, simultaneous with the filing of the Complaint, a statement of material evidence and information in Relator's possession related to the Complaint as well as a copy of this Complaint. The disclosure statement supports the existence of overcharges and false claims by the defendants. MANA is the original source of this information under the Act.

7. Defendant Allina Health System Corp. ("Allina") is a nonprofit corporation and integrated health care system.

8. Defendant Unity Hospital ("Unity") is a hospital operating at 550 Osborne Road in Fridley, Minnesota.

9. Defendant Mercy Hospital ("Mercy") is a hospital operation at 4050 Coon Rapids Boulevard in Coon Rapids, Minnesota.

10. Defendant John Murphy currently and was at all times pertinent hereto Vice President of Unity and Mercy Hospitals. He was personally advised by CRNA members of MANA of the fraud alleged herein in 1992.

11. Defendant Midwest Anesthesiologists, P.A. ("MAPA") is a Minnesota professional association which

engages in, among other things, the provision of anesthesia services to the defendants Unity and Mercy Hospitals.

12. Defendant Metropolitan Anesthesia Network ("MAN") is a professional corporation which owns and controls MAPA, as well as other professional associations with anesthesiologists with privileges at Unity and several other Minnesota Hospitals.

13. Health Billing Systems, Inc. ("HBS") is a Minnesota corporation which is owned and controlled by MAN and is responsible for providing billing services to MAN and MAPA employees. On information and belief, Allen Tank is a principal of HBS.

14. Defendant Allen Tank ("Tank") at all times pertinent hereto was an employee of either HBS, MAN or MAPA and performed business management functions for these groups, including billings for anesthesia which it is alleged were deceptive and fraudulent.

15. Defendants Thelma M. Albay, M.D. ("Albay"), Gary Baggenstoss, M.D. ("Baggenstoss"), Minda Castillejos, M.D. ("Castillejos"), David Cumming, M.D. ("Cumming"), Teri Heil, M.D. ("Heil"), Sang Hong, M.D. ("Hong"), Ted Janossy, M.D. ("Janossy"), Raymond Kloepper, II, M.D. ("Kloepper"), John Magdisick, M.D. ("Magdsick"), Thomas Maggs, M.D. ("Maggs"), Thomas Polta, M.D. ("Polta"), John Roseberg, M.D. ("Roseberg"), Jai Suh, M.D. ("Suh"), Mark Sperry, M.D. ("Sperry"), Jeffrey Yue, M.D. (Yue") and John Rydberg, M.D. ("Rydberg") are medical doctors specializing in anesthesia ("MDAs") who maintained privileges at Unity and/or Mercy Hospitals at all times relevant to this Complaint and are members of MAPA (hereinafter collectively the "Unity/Mercy MDAs").

16. The defendants named in paragraphs 7 through 15 shall be collectively referred to as the "Unity/Mercy defendants".

17. Defendant St. Cloud Hospital ("St. Cloud") is a hospital operating at 1406 6th Avenue N., St. Cloud, Minnesota 56303.

18. Defendant Anesthesia Associates of St. Cloud Ltd. ("AASC") is a professional partnership located at 816 West St. Germain St. Suite 403, St. Cloud, Minnesota 56301, whose anesthesiologists members maintain privileges at St. Cloud Hospital.

19. Defendants Gary A. Boeke, M.D. ("Boeke"), Philip F. Boyle, M.D. ("Boyle"), L. Michael Espeland, M.D. ("Espeland"), Alan D. Espelien, M.D. ("Espelien"), Paul J. Halverson, M.D. ("Halverson"), Craig Johnson, M.D. ("Johnson"), Lanse C. Lang, M.D. ("Lang") and A. Wade McMillan, M.D. ("McMillan"), William H. Rice, M.D. ("Rice"), Allan Reitz, M.D. ("Reitz") and Annette E. Zwick, M.D. ("Zwick") are medical doctors specializing in anesthesia ("MDAs") who maintained privileges at St. Cloud Hospital at all times relevant to this Complaint and are members and/or employees of AASC.

20. Defendants in paragraphs 17 through 19 will hereinafter collectively be referred to as the "St. Cloud defendants."

21. Defendant Anesthesiology, P.A. ("APA") is a professional association which, among other things, provides anesthesia services to North Memorial Hospital.

22. Defendant Abbott Northwestern Hospital is a hospital operating at East 28th Street, Minneapolis,

Minnesota. Abbott Northwestern is owned by defendant Allina.

23. Defendant Northwest Anesthesia, P.A. ("NWA") is a Minnesota professional corporation which, among other things, provides anesthesia services to Abbott Northwestern.

24. Defendants Bryce Beverlin, M.D. ("Beverlin"), Richard Blomberg, M.D. ("Blomberg"), Jean Boening, M.D. ("Boening"), Mitchell Burke, M.D. ("Burke"), Rajarao Dwarakanath, M.D. ("Dwarakanath"), Richard Engwall, M.D. ("Engwall"), James Gayes, M.D. ("Gayes"), Luis Giron, M.D. ("Giron"), Nancy Groves, M.D. ("Groves"), Jonathan Gudman, M.D. ("Gudman"), Richard Johnson, M.D. ("Johnson"), John Lillehei, M.D. ("Lillehei"), Robert McKlveen, M.D. ("McKlveen"), Judith Meisner, M.D. ("Meisner"), Michael Menzel, M.D. ("Menzel"), James Musich, M.D. ("Musich"), Mark Nissen, M.D. ("Nissen"), Xavier Pereira, M.D. ("Pereira"), David Plut, M.D. ("Plut"), Jeffrey Shaw, M.D. ("Shaw"), Richard Skoog, M.D. ("Skoog"), William Stauffer, M.D. ("Stauffer"), Ofelio Tiu, M.D. ("Tiu"), Robert Tronnier, M.D. ("Tronnier") and John Wintermute, M.D. ("Wintermute") are medical doctors specializing in anesthesia ("MDAs") who maintained privileges at Abbott Northwestern Hospital at all times relevant to this Complaint and are members and/or employees of NWA (hereinafter collectively the "Abbott Northwestern MDAs").

25. Defendants in paragraphs 22 through 24 will hereinafter collectively be referred to as the "Abbott Northwestern" defendants.

26. Plaintiffs sue fictitious defendants Does I through XX, inclusive, because their names and/or capacities and/or facts showing them liable are not presently known.

27. All of the Hospital defendants named above shall hereinafter alternatively be referred to as "the defendant hospitals."

28. All of the anesthesiologist defendants and their professional associations named above shall hereinafter be collectively alternatively referred to as "the defendant anesthesiologists."

THE ROLES OF ANESTHESIOLOGISTS AND OF CRNAs IN THE PROVISION OF ANESTHESIA

29. Anesthesia is a medical specialty which deals with the management of procedures for rendering a patient insensible to pain during surgical, obstetrical and certain other medical procedures; the support of life functions under the stress of anesthetic and surgical manipulation; the clinical management of the patient unconscious for whatever cause; the management of problems in cardiac and respiratory resuscitation; the application of specific methods of inhalation therapy; and the clinical management of various fluid electrolyte and metabolic disturbances.

30. Certified registered nurse anesthetists are a group of health providers who are virtually unknown to the public at large, yet they administer more the 65% of the 26 million anesthetics given to patients each year in the United States. In 85% of rural hospitals, CRNAs are the *sole* anesthesia providers providing all aspects of

anesthesia, including obstetrical, surgical and trauma stabilization services. While anesthesiologists, who are physicians, are often involved in the delivery of anesthesia services as part of an anesthesia care team, they are frequently absent from the operating room during the administration of anesthesia and for long periods of time during the surgery. It is the CRNA who, in most cases, performs the majority of the anesthesia services and who stays in the operating room with the patient and the surgeon throughout the operation.

31. The principal activity of most anesthesia providers who are in the clinical practice of medicine is in connection with the performance of surgery in a hospital. Ordinarily the patient about to undergo surgery does not choose his anesthesia provider. That decision is usually made by the surgeon or assigned to the patient's case by the operating room supervisor or head of the anesthesia department. It is not uncommon for a patient to have his first contact with the anesthesia provider just prior to being brought into the operating room for surgery.

32. Historically, since World War II, while anesthesia services have been provided in a variety of settings, including CRNAs only, anesthesiologists only, and CRNAs under the direction of physicians or anesthesiologists, the majority of anesthesia care in the United States has been provided by way of anesthesia care teams. The anesthesia care teams are made up of a number of CRNAs who provide the majority of the anesthesia and related services under the direction of and/or supervision of an anesthesiologist. Such teams are the most cost effective method of providing anesthesia care since they utilize lower cost providers, CRNAs, and they minimize the involvement of

substantially higher cost providers, anesthesiologist MDAs.

MEDICARE REGULATIONS RELEVANT TO DEFENDANTS' FALSE CLAIMS

33. Since, on average, hospitals in the Twin Cities area, including defendant hospitals, that provide general surgical services provide approximately 30% of those services to Medicare related patients, Medicare strongly affects the way those hospitals operate. In addition, many private insurers look to Medicare regulations to guide their insurance reimbursement policies.

34. Reimbursement for the provision of anesthesia services has been treated uniquely by Medicare.

35. Prior to 1982, anesthesiologists billed under Part B of Medicare as independent health care practitioners, whereas CRNAs' costs were billed by the hospital under Part A as part of the general costs of providing Medicare services.

36. Under pre-1982 Medicare regulations, anesthesiologists were permitted to supervise as many CRNAs as they wished and to bill for as many cases simultaneously as they wished. There was no limit of the number of concurrent cases for which an anesthesiologists could receive reimbursement for medically directing CRNAs, even though the direct participation of the MDA may have been minimal.

37. In 1982, in part as a result of what was believed to be widespread fraudulent billing practices by MDAs, the Tax Equity and Fiscal Responsibility Act of 1982

("TEFRA") was enacted, establishing conditions for anesthesiologists to fulfill in order to be paid for medically directing CRNAs. Those conditions were:

(a) Performs a pre-anesthesia examination and evaluation;

(b) Prescribes the anesthesia plan;

(c) Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence;

(d) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;

(e) Monitors the course of anesthesia administration at frequent intervals;

(f) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provides indicated post anesthesia care.

38. Subsequently Congress passed the Omnibus Budget Reconciliation Act of 1986 ("OBRA '86"), which established the ability for CRNAs to bill directly under Medicare Part B effective January 1, 1989. In practice, since most CRNAs were employed by hospitals, they assigned their independent billing rights to the hospitals, which billed Medicare for the CRNAs' services.

39. Another crucial change which was introduced in OBRA '86 was a change in the methodology for payment of anesthesiologists and nurse anesthetists. 42 C.F.R. 414.450 provided that, in most cases where an anesthesiologists was engaged in a single procedure and was not

involved in any other concurrent cases, the anesthesiologists would be paid 100% of the cost of the procedure regardless of whether any nurse anesthetists was involved. Thus, in such cases, often referred to as "one-on-ones," the anesthesiologists may be paid for 100% of the work even if the CRNA performs the work. In contrast, if an anesthesiologist is involved in two, three or four concurrent cases, he will receive only a portion of the allocated cost of the procedure and the other portion will be paid to the CRNA. This change was crucial because it permitted an MDA, by fraudulently billing concurrent cases as "one-on-ones," to increase the amount he was paid by Medicare substantially beyond that which he should have been paid.

DEFENDANTS' FALSE CLAIMS

40. This *Qui Tam* complaint is based upon the fact that for years the defendant anesthesiologists, with the knowledge and active assistance of the defendant hospitals, have been billing Medicare for services which they either did not perform or which did not qualify for reimbursement under the applicable Medicare laws and regulations. In particular, while the Medicare regulations pertaining to reimbursement for anesthesia services have been amended from time to time, since January 1988 an anesthesiologists was only entitled to be personally reimbursed for services provided by him in three specific situations, two of which are relevant here: (1) where he personally performs the anesthesia procedure; and (2) where he medically directs another qualified anesthesia provider (such as a CRNA) in connection with two, three or four procedures.

41. In order to be reimbursed for personally performing the anesthesia procedure, the anesthesiologist is required to either (1) "personally perform the entire anesthesia procedure (42 C.F.R. 414.46 (2) (i); or (2) be "continuously involved in a single case involving a certified registered nurse anesthetist ("CRNA"), an anesthesiologist assistant ("AA") or a student nurse anesthetist" (42 C.F.R. 414.46 (2) (ii)). Cases where one MDA works with one CRNA are often referred to as "one-on-one" cases.

42. In order to be continuously involved in a single case, the anesthesiologist must be present in the operating room for the entire time. In particular, 42 C.F.R. 4:14.46 provides that billing for anesthesia services is based upon base units which assign a value to each anesthesia procedure and "time units" which "involve the *continuous actual presence* of the physician . . . and starts when he or she begins to prepare the patient for anesthesia . . . and ends when the anesthesiologist . . . *is no longer in personal attendance*." In contrast, where the physician is "medically directing" a CRNA which may only occur in connection with two, three or four concurrent procedures, time units may be billed based on the "presence" of the "medically directed" CRNA. Because the MDA must be present with the CRNA at all times to be reimbursed for personally performing a procedure, Section 4:14.46 also provides that where the anesthesiologist personally performs the procedure, he receives the full fee and no payment will be made to the CRNA unless the CRNA's presence is "medically necessary". See 42 C.F.R. 4:14.46 (c) (3). The requirement that an anesthesiologist must be in the operating room for the entire time if he seeks to be reimbursed for personally performing a procedure and may not be engaged for any amount of time in other activities was confirmed on

numerous occasions in letter interpretations issued by the Department of Health & Human Services. On December 9, 1987 the Director of the Office of Reimbursement Policy, Bureau of Eligibility, Reimbursement Coverage responsible for officially interpreting Medicare regulations regarding reimbursement wrote to St. Cloud defendants' Medicare carrier, Blue Shield and stated the following:

> "It is our opinion that 42 CFR 405.552 (a) (2) refers to two patterns of anesthesia administration payable on a reasonable charge basis. Either the anesthesiologist performs the procedure directly without the assistance of an anesthetist or the anesthesiologist medically directs anesthesia during concurrent procedures. Medical direction would occur in the context of concurrent procedures not a single procedure. In the situation where the anesthesiologist is involved in a single anesthesia procedure involving a CRNA, we would deem the procedure to be performed by the anesthesiologist . . . we would deem an anesthesia procedure as personally performed by an anesthesiologist as long as the anesthesiologist was *continuously present with the CRNA* for those services that the anesthesiologist does not personally perform and the anesthesiologist is not involved in any other anesthesia procedure."

Subsequently in its administrative bulletins issued in March 1988 to defendant anesthesiologists Blue Cross/Blue Shield stated:

> "We deem the anesthesia procedure as personally performed by the anesthesiologist as long as the anesthesiologist was continually present with the

> CRNA for those services that the anesthesiologist does not personally perform and the anesthesiologist is not involved in any other anesthesia procedure."

Again, on August 10, 1990, Blue Cross/Blue Shield issued another bulletin stating in pertinent part

> "Personally furnished anesthesia services are provided personally by the anesthesiologist to an individual patient. You cannot bill for personally furnished anesthesia if you are also simultaneously involved with the delivery of anesthesia services for any other patient."

Furthermore, in a memorandum to defendant, John Murphy, on December 14, 1992, is written:

> In order to qualify to receive reimbursement for personal delivery (1/1) of a service, the anesthesiologist must be *continuously present* with the CRNA (if a CRNA is also involved) for those services, the anesthesiologist does not personally perform, and the anesthesiologist cannot be involved in any other anesthesia procedure." (April 1988 Medicare Bulletin, Administrative Bulletin #177.)

Finally, as recently as January 7, 1994, Bernard Patashnick, Director of the Division of Medical Services Payment Bureau of Policy Development wrote to the American Society of Anesthesiologists stated the following:

> "The anesthesiologist who is billing for personal performance of the case *must personally perform the case*. In theory, there is *no one else to hand the case to*. In the medically directed case we do not require the anesthesiologist to personally perform all anesthesia activities. In fact, many of these activities are performed by the CRNA."

Consequently, an MDA cannot bill one-to-one if the foregoing criteria are not met, even if the MDA participated in some portion of the process. As recently as April 1996, HCFA confirmed in a letter to the private carrier who administers defendant MDAs' claims that HCFA requires the anesthesiologist to remain in the operating room in billing for personally performed cases. In that same letter, HCFA confirmed that medical direction of single procedures does not exist. Defendants have been provided with copies of this letter.

43. The defendant hospitals were on notice as early as December 19, 1987, that the defendant anesthesiologists were billing fraudulently. Moreover, between 1990 and 1992, CRNAs at those hospitals reported the fraud. For example, at Unity Mercy, copies of charts showing that MDAs were fraudulent [sic] billing and were actually in other operating rooms at the time were provided to in-house counsel for Allina and to defendant Murphy, yet the hospital did not report this fraud to any governmental agency. At St. Cloud Hospital, Jerry Boldon, a CRNA, wrote a memo disclosing the fraud to administrators. However, instead of taking steps to stop the MDA's fraud, the hospitals fired Relator's members who had brought the fraud to their attention and knowingly facilitated the continuation of the fraud.

44. Relator's members have personal knowledge that defendant anesthesiologists have routinely billed Medicare for personal performance of anesthesia procedures in which they were *not* continuously involved or present, as required by Medicare. Those bills were for services for which the defendant anesthesiologists knew they were not entitled to reimbursement from Medicare, and were false or fraudulent claims within the meaning of 31 U.S.C.

3729. Defendant MAN used the services of defendants Tank and HBAS who knowingly billed on their behalf for services which they knew or should have known were not performed by them.

45. The second basis for Medicare reimbursement of a physician anesthesiologist is for medically directing a CRNA or other anesthesia provider in two, three or four concurrent anesthesia procedures. In order to be entitled to such reimbursement, the anesthesiologist need not be present in the operating room at all times. As previously noted, however, he must comply with the following conditions:

(1) For each patient, the physician must –

(i) Perform a preanesthetic examination and evaluation;

(ii) Prescribe the anesthesia plan;

(iii) Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence;

(iv) Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions;

(v) Monitor the course of anesthesia administration at frequent intervals;

(vi) Remain physically present and available for immediate diagnosis and treat of emergencies; and

(vii) Provide indicated post-anesthesia care.

42 C.F.R. 405.552.

46. Relator's members have personal knowledge that during the past six (6) years defendant anesthesiologists have billed for medically directed services and personally performed services without complying with the conditions set forth in 42 C.F.R. § 405.552. Those bills were for services for which the defendant anesthesiologists knew they were not entitled to reimbursement from Medicare and were false or fraudulent claims under Section 3729.

47. In particular, defendant Northwest Anesthesia engaged in similar false billing practices and false claims in connection with the provision of anesthesia services at Abbott Northwestern Hospital. For example, anesthesiologists who work for NWA and provide services at Abbott Northwestern have on numerous occasions billed for personally performing operations when they were only present in the operating room for a fraction of the actual anesthesia time. Relator has supplied to the Government affidavits from members of MANA who have been at Abbott Northwestern which state that the anesthesiologists who provided anesthesia services at operations in which those CRNAs were involved were "virtually never present for the entire time." Similar statements confirm that anesthesiologists often left the operating room after starting cases late in the day and never returned. Relator has also obtained and supplied to the Government numerous rejection documents reflecting operations or procedures which were billed by the defendant Abbott Northwestern anesthesiologists as "personally performed" which Relator is informed and believe were false and fraudulent. In order to facilitate this fraud, Allina and Abbott Northwestern have announced plans to terminate all of their CRNA employees. Relator and the Government are informed and believe that this termination was not

because the CRNAs were not economically viable but rather in order to force the CRNAs to be employed by the defendant MDAs and thereby to simultaneously distance the hospital from the defendant anesthesiologists' fraudulent billing practices.

48. Defendant anesthesiologists also contravened the requirements of §405.552 as follows. Medicare does not provide reimbursement to anesthesiologists in a group practice for medical supervision of a procedure where one member of the group substitutes for another during the course of the procedure, except as follows:

> If anesthesiologists are in a group practice, one physician member may provide pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who rendered them.

CCH Medicare and Medicaid Guide, ¶3455.40, *Medicaid Carriers Manual*, §15018 (C). Relator's members have personal knowledge that defendant anesthesiologists in group practices billed Medicare for medical direction of procedures during the course of which one group member had taken over the procedure from another under circumstances which precluded reimbursement from Medicare. Those bills were for services as to which the defendant anesthesiologists knew they were not entitled to reimbursement from Medicare, and were false or fraudulent claims within the meaning of 31 U.S.C. §3729. The defendant

anesthesiologists have knowingly concealed such false claims by failing to sign in and out of the operating room during such procedures, thereby depriving Medicare of a standard medical record which, if fully and accurately prepared, would reveal defendants' fraud. Defendant hospitals have assisted them in this fraud by refusing to require them to sign in and out of the operating room, and in the case of defendants Unity and Mercy, by refusing to require defendant anesthesiologists to carry "pagers" or "beepers."

49. As CRNA's who daily worked alongside the defendant anesthesiologists at the defendant hospitals, Relator members have personal knowledge of defendants' false claims by virtue of communications with defendants themselves, participation in the anesthesia procedures which were later fraudulently billed by the defendant anesthesiologists, and familiarity with hospital records disclosing defendants' fraud.

DEFENDANTS' FRAUDULENT SCHEME

50. As previously alleged, since the 1983 TEFRA regulations went into effect in November 1983, Medicare has only recognized two ways for anesthesiologists to be paid for anesthesia services: (1) personally performing a procedure and (2) medically directing 2, 3, or 4 procedures. HCFA has never recognized medical direction of one procedure. As early as 1987, in a letter to one of the Minnesota carriers to which defendants had access, Charles Booth, Director of Policy and Reimbursement for HCFA, stated in no uncertain terms that there is no such thing as medical direction of a single procedure. Moreover, in order to bill for personal performance of a procedure,

the anesthesiologist must either (1) personally perform every aspect of the anesthesia procedure on the patient and be present for the entire time, or (2) be continuously present with the patient and a CRNA and continuously involved with the case. These requirements make simple common sense since when the anesthesiologist is involved in a procedure with one CRNA, he is paid as if he performed every aspect of the procedure by himself without assistance and in most cases the CRNA receives nothing.

51. The requirement of continuous presence in the operating room has been repeated by HCFA since 1987. It is contained in Bulletins issued by Blue Cross/Blue Shield, the carrier for the St. Cloud defendants; it is contained in letters to the American Society of Anesthesiologists which were republished in Newsletters available to defendants; and it was enforced by government enforcement authorities in Minnesota who investigated another hospital owned by the Allina defendant for similar types of fraud.

52. As for medical direction of two, three and four procedures, the rules are very strict if an anesthesiologist seeks to be reimbursed. Of particular interest in this case, the anesthesiologist must be present in the operating room with the patient and personally participate in all demanding aspects of the anesthesia plan, even though he may be absent from the operating room at other times to monitor concurrent cases. In particular, the anesthesiologist must be present at induction when the anesthetic is first introduced into the patient at the beginning of the case and at emergence when the surgery has been completed and the patient is being revived from the anesthetic. Moreover, in any event, the anesthesiologist must be present at the end of the case because it is at that time that the anesthesiologist must make a determination as to whether or not the

patient is in sufficiently stable condition to be turned over to a non-anesthesia provider.

53. A second requirement which is required to be satisfied to be reimbursed for medical direction of concurrent procedures is that the anesthesiologist must remain present and immediately available for diagnosis and emergencies. It goes without saying that the anesthesiologist cannot be involved in any other procedures other than the concurrent procedures for which he is billing and must bill the concurrencies correctly. For example, it is improper for bill Medicare for medically directing two procedures if, in fact, the anesthesiologist is involved in four concurrent procedures.

54. Failure to satisfy any of the above requirements disqualifies the anesthesiologist from reimbursement for medical direction and submission of such a bill knowingly or with blind or reckless disregard for its truth constitutes a false claim under the False Claims Act. The defendant anesthesiologists enumerated in the caption to this Complaint have routinely submitted bills to Medicare when they did not satisfy the above requirements.

55. The defendant hospitals, including Abbott Northwestern, St. Cloud, Unity and Mercy have actively assisted the defendant anesthesiologists in submitting those fraudulent bills, abetted their behavior, attempted to conceal the fraud and chill reporting of the fraud by relator's members and, in addition, plaintiffs believe have submitted false claims directly themselves which could have resulted or did result in overpayments by Medicare.

56. The general fraudulent scheme carried out by the defendant anesthesiologists practicing at the defendant hospitals was to provide loose "supervision" of the

CRNAs who were employed by defendant hospitals in a manner which failed to satisfy either the requirements for "medical direction" or for "personal performance", yet to bill Medicare as if they had in many cases "personally performed" the procedure and in other cases, "medically directed" the procedure. The direct consequences of this was that CRNAs' bills submitted on behalf of the CRNAs who actually performed the procedures were not paid at all or were dramatically reduced from the payments to which they were entitled.

57. MANA has further corroborating evidence of defendants' false claims in the form of contemporaneous records that were kept by MANA members. In particular, MANA members Drew Mathews and Charles Hauwiller kept a record and recorded on the patient's anesthesia record over a several year period when defendants left the room and failed to appear for emergence. These records have already been provided to the defendants and are incorporated herein by reference. Kristi Vogt, another MANA member employed at North Memorial Hospital, recorded the defendants' presence or absence at emergence on the anesthesia record. These records are in the possession of defendant Anesthesiology, P.A. and North Memorial Hospital and are incorporated herein by reference. With particularity, the types of fraud engaged in by the anesthesiologists at each of the defendant hospitals was the following.

FALSE CLAIMS ASSOCIATED WITH FAILURE TO PARTICIPATE IN THE MOST DEMANDING PROCEDURES OF THE ANESTHESIA PLAN

58. The defendant MDAs practicing at unity, Mercy and North Memorial Hospitals failed to participate in

either emergence or the most demanding part of the anesthesia plan in virtually every anesthesia procedure performed there in violation of 42 C.F.R. 405.552. Instead, defendants' general practice at those hospitals was to appear for induction at the time that the anesthesia was being provided to the patient, to leave approximately 10 minutes later and to seldom, if ever, return at all. Instead, the CRNA who was the only anesthesia provider left in the operating room, would perform all of the procedures necessary to maintain the patient in the appropriate state of unconsciousness, to bring the patient out of the anesthesia, to extubate the patient when appropriate, and to make the decision whether or not the patient was stable enough to be transferred to a non-anesthesia provider such as the post-anesthesia care unit. For those cases billed as MAC (monitored anesthesia care), it was common practice for MDAs at Mercy, Unity and North Memorial to *never enter the operating room at all*, or only long enough to sign the anesthesia record. While there was some very small percentage of cases in which Unity, Mercy and North Memorial defendants were present at emergence and at extubation a minimum of 95% of the time they were not present as required by Medicare in any Medicare case.

59. The Abbott Northwestern and St. Cloud defendants were present more often at emergence. However, approximately 5% of the time they failed to satisfy this requirement and, nevertheless, improperly billed Medicare for the procedure. Some representative examples of this practice at each of the aforementioned defendant hospitals are the following (Relators can identify the particular patients involved in the vast majority of procedures detailed in this Third Amended Complaint. However,

these names have not been included to protect those patient's confidentiality):

Date of Procedure Associated With False Claim	**Defendant MDA**	**Summary of Procedure**
1. Location Defendant Unity and Mercy		
12/29/93	Albay	Billed for extensive repair of a vagina. The procedure lasted 1 hour and 30 minutes. Contemporaneous records of Drew Mathews demonstrate that defendant Albay was only present for approximately 20 minutes at the beginning of the case and did not return for emergence.
1/12/94	Heil	Billed for medical direction of an operation. Drew Mathews' contemporaneous record shows that Heil was present for only 20 minutes out of a 1 hour 40 minutes operation and was not present at emergence.
2/2/94	Sperry	Billed for medical direction of a case that lasted 1 hour and 10 minutes in connection with surgery to repair a superficial wound. Drew Mathews' contemporaneous record shows that Defendant Sperry was only present for 20 minutes and was not present for emergence.

3/2/94	Magdsick	Billed for an operation in OR-3 at Unity Hospital which began at 7:25 and ended at 9:20. In fact, during this procedure he was attending a meeting with the Critical Care Committee which commenced at 8:00 a.m. and was not available for the emergence of the patient.
3/16/94	Albay	Billed for an operation lasting 1 hour and 10 minutes. Drew Mathews' contemporaneous record shows that Defendant Albay was present only for approximately 15 minutes at the beginning of the case and was not present at emergence.
3/21/94	Jones	Billed for Medically directing three operations when, in fact, he was involved in four concurrent operations. Further, Dr. Jones billed for an operation in OR-7 for which he was only present for 20 minutes out of a 3 hours and 35 minutes hysterectomy operation. Drew Mathews' contemporaneous record shows that he was not present at emergence.

2. Location North Memorial

9/14/95	Everly	Billed for personally performing a case when he was not there at emergence.
11/15/93	Lader	Billed for personally performing a case when he was not there at emergence.

In addition, as previously stated, the North Memorial defendants were absent at emergence approximately 95% of the time in all cases, including Medicare cases. With specificity, plaintiffs allege that in every case in which Kristi Vogt was a CRNA, to the extent she did not note on the medical records that defendant MDAs were present at emergence, they were absent. The dates, times, locations and other relevant information concerning these false claims are within the possession of defendant Anesthesiology, P.A. and North Memorial Hospital. Plaintiff has requested this information but has not yet received it.

3. Location defendant Abbott Northwestern Hospital

12/19/95	Meisner	Failed to participate in emergence in a case performed in the main operating room in the basement of Abbott Northwestern Hospital. Her failure to do so was based upon her involvement in medically directing a case in the minimally invasive unit five floors above.
6/1/95	Engwall	Was responsible for a case at Abbott Northwestern Hospital. Charles Hauwiller was

		the CRNA on the case. Engwall left for lunch and no anesthesiologist relieved him or came into the room after he left. No anesthesiologist was present at the end of the case during emergence. Defendant Engwall was paged several times during the case but failed to appear at the end of the case.
10/5/95	Engwall	Was responsible for a case at Abbott Northwestern Hospital. Charles Hauwiller was the CRNA on the case. Defendant Engwall was at lunch throughout the case and never entered the operating room from the beginning until the end of the case.
3/1/95	Engwall	Was responsible for an anesthesia case in the basement while at the same time taking responsibility for a concurrent case in the minimally invasive center on the fifth floor. Despite being paged twice, defendant Engwall did not return for emergence or extubation. Defendants McKlveen, Skoog, Nissen and Musich were also paged, however, no MDA appeared for emergence of the patient.

Drew Mathews Records

In addition, Drew Mathews recorded on the anesthesia records in scores of instances when MDAs at Unity were not present at emergence. The dates and times of these procedures are on records currently solely in defendants' possession.

4. Location defendant St. Cloud Hospital

8/26/94	McMillan	Started a case at 10:40 a.m. and turned the case over to defendant Rice at 11:56 a.m. The first cased ended at 13:15. Rice started another case at 13:12 and neither McMillan nor Rice were present for the emergence of the patient at the end of the case yet McMillan billed under the AA modifier for personally performing the case.
5/31/90	Gacusana	Was performing an operation at St. Cloud Hospital in OR-1. He billed for personally performing this procedure even though he was also involved in and responsible for a procedure in OR-4 which commenced 1 minute before the procedure in OR 1 and ended 40 minutes after the procedure in OR-1. This bill was fraudulent both on the basis of Gacusana's failure to be present and participate in the most demanding procedures of the anesthesia plan and also on the basis

		that he did not remain in the room with the patient. Medicare rejected the CRNA's bill for the operation in OR-1 on the basis that Defendant Gacusana billed it as "personally performed."
3/18/94	Johnson	Billed Medicare for personally performing a case where he had become ill and leftthe room shortly after induction and never returned. In fact, Defendant Johnson was attached to an IV in the doctors' lounge while this procedure was occurring. Based on the anesthesia record, which was altered by defendant Zwick, no anesthesiologist was responsible for the case between 15:15 and 16:33.
2/4/92	Espelien	Billed for a procedure in St. Cloud Hospital under the AA modifier which began at 10:51 and ended at 13:58. This whole time defendant Espelien billed for an anesthesia procedure which commenced at 12:25 in another operating room and ended at 13:25. The two procedures were concurrent. Moreover, because he was not present in the room the entire time and was, in fact, involved in other procedures, Defendant Espelien did not qualify to bill the procedure as personally performed.

FALSE CLAIMS ASSOCIATED WITH FAILURE TO FULFILL REQUIREMENTS OF PERSONAL PERFORMANCE

60. In addition, the defendant MDAs practicing at St. Cloud, Unity, Mercy, North Memorial and Abbott Northwestern Hospitals were never present in the operating room with the patient and the CRNAs in 1:1 cases for the entire anesthesia time as required by Medicare for any Medicare procedure between January 1988 and June 14, 1996. While their reasons for these absences from the operating room varied including, among others: (1) providing servcies on a time billed basis to other patients; (2) providing services on a fixed fee basis to other patients; (3) sleeping; (4) reading or attending to personal business on the phone; (5) attending meetings or performing duties on other floors; (6) being attached to an IV and receiving fluids in the doctors' lounge; (7) watching Star Trek; (8) watching Vikings football games; (9) leaving the hospital; or (10) engaging in other activities. Their failure to be present with the CRNA and patient for the entire anesthesia service time in these procedures disqualified them from billing for personally performing anesthesia procedures to Medicare. In May 1994 MAPA defendants even discussed adopting a policy whereby they would start cases at one hospital and leave to do cases at the other hospital.

61. In violation of the False Claims Act, the aforementioned defendants nevertheless filed at least 40,000 bills to Medicare under the "AA" modifier claiming that they personally performed procedures between January 1988 and the date of this Third Amended Complaint. The specific dates and time of these procedures is set forth in computer printouts in MANA's possession, as well as in

records maintained by the defendants and by MetraHealth Ins. Co. A summary of many of the bills submitted by each of the defendant anesthesiologists is annexed hereto as Exhibit "A" and incorporated herein by reference. Since the printouts of the individual procedures and billing information in question cover over 250,000 separate bills and instances, they are not annexed to this Third Amended Complaint. However, they are incorporated herein by reference and are available in plaintiffs' counsel's office for review by defendants should they desire to do so. Additional billing information is in the possession of defendants' Medicare carrier. Representative examples of what plaintiffs believe to be fraudulent claims by these defendants based upon their failure to be present with the patient in the operating room for the entire anesthesia time are as follows:

Date of Procedure Associated With False Claim	**Defendant MDA**	**Summary of Procedure**
Location Defendant Mercy Hospital		
6/9/92	Janossy	Defendant Janossy billed Medicare for personally performing a heart case from 8:30 to 23:55. He billed for a *second* Medicare case, which started at 7:35 and ended at 8:50, as though there were two concurrent cases. During the span of the first case he billed *nine* other cases on non-Medicare patients: (1) 9:04 to 9:20; (2) 9:10 to 10:55;

		(3) 9:33 to 11:15; (4) 11:15 to 11:45; (5) 12:45 to 13:35; (6) 12:30 to 17:35; (7) 17:35 to 18:35; (8) 7:48 to 8:45; and (9) 8:45 to 9:00. At 8:45, he was involved in four concurrent cases. Therefore both the first and the second Medicare cases were fraudulently billed.
11/2/89	Baggenstoss:	He billed for personally performing an operation in OR-4 which began at 11:20 and ended at 12:20. However, at the same time, he was also performing a procedure in OR-7 which began at 10:57 and ended at 11:55. Under the rules, these were concurrent procedures and it was fraudulent to bill either one of them as personally performed.
8/21/90	Suh	He billed for personally performing an operation in OR-2 between 18:50 and 21:20 when the records indicate he was also performing an anesthesia procedure in OR-5 between 20:45 and 23:40. These were concurrent procedures and it was fraudulent to bill them as personally performed.

7/2/90	Sperry	He billed for performing an operation in OR-2 which lasted 1 hour and 45 minutes and began at 7:25 and ended at 8:50. However, at the same time, in OR-4, he was involved in an anesthesia procedure which began at 8:05 and ended at 8:20. These procedures are clearly concurrent procedures and billing one or both of them as personally performed was fraudulent.
9/20/89	Baggenstoss	He billed for an operation in OR-3 as personally performed. The operation lasted over 7 hours beginning at 19:15 and ending at 2:30. At the same time, he was performing anesthesia procedures in OR-2 beginning at 18:05 and ending at 19:35 and OR-2 beginning at 20:25 and ending at 21:50. Both of these operations overlap the personally performed operation and, therefore, they should have been billed as concurrent medically directed operations. Billing one or more of them as personally performed was fraudulent.

11/15/89	Baggenstoss	He billed for personally performing an operation which lasted 7.5 hours between 10:30 and 18:15. At the same time, he billed for performing an anesthesia procedure and operating in OR-2 which began at 16:55 and ended at 18:10. These two operations clearly overlapped under the Medicare regulations and billing one or more of them as personally performed is clear fraud.
10/11/89	Jernigan	He billed for personally performing an operation in OR-9. The procedure lasted two hours. It began at 12:30 and ended at 14:25. At the same time, he was billing for an anesthesia procedure in OR-2 which began at 11:50 and ended at 14:30. These two operations clearly overlapped and billing one or more of them as personally performed was clearly fraudulent.
3/7/94	Magdsick	He billed for personally performing an operation in OR-10. The operation lasted 11 hours and 25 minutes and began at 6:35 and ended at 18:00.

		During that same time period, Defendant Magdsick billed for an anesthesia procedure in OR-6 which began at 11:15 and ended at 12:40 and an anesthesia procedure in OR-8 which began at 11:48 and ended at 12:35. The first bill is clearly fraudulent since all of these operations were concurrent. The other two bills may also be fraudulent, however, they have not been provided to us.
3/10/94	Suh	Defendant Suh was performing a catscan and an X-ray between 12:45 and 15:30 and billed for same. At the same time he billed for performing anesthesia procedures in *another part of the hospital* in OR-3, the first procedure beginning at 12:50 and ending at 13:02 and the second procedure beginning at 13:20 and ending at 15:00. Both these procedures were ongoing while Defendant Suh was apparently in another part of the hospital performing a catscan. Clearly he was not present and available to attend to any emergencies that might arise regardless of how he may have billed those procedures.

Location Defendant Unity Hospital

2/7/92	Castillejos	Billed for personally performing a case from 11:00 to 12:05 while at the same time doing another case from 10:20 to 11:20.
10/7/92	Hong	Billed for personally performing a case from 12:25 to 16:00 while at the same time billing for a procedure from 12:15 to 13:05 and from 14:25 to 15:25.
1/24/92	Heil	Billed for personally performing a case from 15:20 to 17:25 while at the same time billing for a procedure from 13:30 to 15:50.
3/28/92	Magdsick	Billed for personally performing a case from 8:15 to 16:20 while at the same time billing for a procedure from 12:20 to 13:35.
11/25/92	Albay	Billed for personally performing a case from 10:25 to 14:45 while at the same time billing for a procedure from 13:30 to 15:15.
2/15/93	Albay	Billed for personally performing a case from 7:35 to 8:30 while at the same time billing for a procedure from 7:30 to 7:45 and from 7:50 to 8:05.
7/19/93	Polta	Billed for personally performing a case from 9:20 to 19:20

		while at the same time billing for a procedure from 7:30 to 11:15 and another case from 11:55 to 12:55.
Location Defendant St. Cloud Hospital		
5/31/90	Gacusana	Gacusana billed for personally performing in this opration in OR-1. It began at 12:35 and ended at 13:03. At the same time, Defendant Gacusana was billing for an operation in OR-4 which began at 12:34 and ended at 13:43. The CRNA's bill for the prior operation was rejected by Medicare. Accordingly, Defendant Gacusana's bill was clearly fraudulent.
2/4/92	Espelien	He billed for personally performing an operation which began at 10:51 and ended at 13:58. Because of this the bill for the CRNA who actually performed the operation, Mary Stotko, was rejected by Medicare. In fact, Defendant Espelien was also billing for an anesthesia procedure in another operating room which commenced at 12:25 and ended at 13:25. Therefore, his bill for the first operation was fraudulent. The

		CRNA in question had to take this matter all the way to a Judge before she was able to obtain a reversal and be paid the modest amount she was owed for actually performing the case.
8/8/91	Gacusana	He billed for an operation in OR-5 which began at 20:40 and ended at 2:12. He billed for personally performing this operation and as a result the CRNA's bill was rejected by Medicare. During the same time Defendant Gacusana was also billing for an anesthesia procedure that began at 21:40 and ended at 23:00 and an operation that began at 23:11 and ended at 00:17. Thus the bill for personal performance was fraudulent and as a result the bill for the CRNA who performed the work was reected by Medicare.
3/29/90	Johnson	Billed for personally performing a case in OR-8 which began at 7:20 and ended at 10:35. At the same time he was also billing for an anesthesia procedure in OR-10 which began at 7:43 and ended at 10:04.

		These operations clearly overlapped and Defendant Johnson's bill was clearly fraudulent. As a result the bill from the CRNA who performed the case was rejected by Medicare.
2/6/90	Johnson	Billed for personally performing an operation in OR-1 which commenced at 12:05 and ended at 14:55. At the same time he was billing for an anesthesia procedure in OR-4 which commenced at 13:45 and ended at 15:50. There is a discrepancy in the times on the chart and the times on the Anesthesia Daily Log. In any event, these operations clearly overlapped. Defendant Johnson fraudulently billed the first operation as personally performed and as a result the bill from the CRNA who actually performed the work was rejected by Medicare.
3/5/90	Rice	He billed for personally performing a case in OR-1 which began at 14:25 and ended at 15:50. This, by the way, is the same patient that Defendant Johnson had previously fraudulently billed.

		At the same time Defendant Rice was billing for anesthesia in OR-2 which began at 12:20 and ended at 15:10. Again there is a discrepancy between the actual times no the anesthesia record and the times on the computerized Daily Log. In any event the two operations clearly overlap. Defendant Rice fraudulently billed the first operation as personally performed and as a result, the bill for the CRNA who actually performed the operation was rejected by Medicare.
1/12/90	Gacusana	He billed for an operation in OR-5 which commenced at 19:15 and ended at 22:00. At the same time he was billing for an anesthesia procedure in OR-3 which commenced at 20:40 and ended at 22:15. Gacusana fraudulently billed for personally performing the first operation although he was concurrently medically directing another operation., As a result, the bill from the CRNA who actually performed the anesthesia procedure was rejected by Medicare.

11/30/89	Halvorson	He was performing an anesthesia procedure in OR-6 which commenced at 7:45 and ended at 11:15 and billed for personally performing same. At the same time he was billing for an anesthesia procedure in OR-7 which commenced at 7:30 and ended at 9:50. As a result of Defendant Halvorson's fraudulent bill for the first operation, the bill for the CRNA who actually performed the procedure was denied by Medicare.
10/31/89	Johnson	Johnson billed for an anesthesia procedure in OR-1 which began at 7:30 and ended at 9:20. He billed for personally performing this procedure although at the same time he was billing for a procedure in OR-7 which began at 6:55 and ended at 8:25. This case was followed by another case in OR-7 which started 8:45 and ended at 10:55. Both cases in OR-7 were concurrent with the procedure in OR-1. Accordingly, Defendant Johnson's bill for the first operation was fraudulent. As a result of his fraudulent bill, the bill from

		the CRNA who actually performed the procedure was rejected by Medicare.
11/8/89	Boyle	Boyle billed for personally performing an operation that began at 9:55 and ended at 11:05. At the same time he was also billing for a concurrent operation which began at 7:50 and ended at 10:45. The bill for the first operation was fraudulent and as a result the bill from the CRNA who actually performed the procedure was rejected by Medicare.
8/25/89	Evenson	Evenson billed for an operation in OR-7 which began at 14:25 and ended at 16:55. At the same time he was billing for an operation in OR-CR which began at 16:45 and ended at 18:10. Defendant Evenson's bill for the first operation was fraudulent. As a result the bill from the CRNA who actually performed the procedure was rejected by Medicare.
7/24/89	Espeland	He billed for an anesthesia procedure in OR-8 which began at 15:20 and ended at 20:50.

		At the same time he was billing for an anesthesia procedure in OR-3 which began at 18:25 and ended at 18:55. The bill for the first procedure was fraudulent and as a result the bill from the CRNA who actually performed the procedure was denied by Medicare.
11/4/93	Zwick	Zwick started at case at 11:04 in OR-11, and turned this case over to Defendant Boyle at 12:36. She was also doing another case from 9:25 - 11:20, yet she billed the case in OR-11 as personally performed.
7/2/94	Rice	Billed Medicare for personally performing, yet was not continuously involved and the CRNA noted "Doctor Rice notified" when cardiac changes occurred.
5/13/94	Boyle	Boyle billed Medicare for personally performing a case in OR-5 from 18:16 to 19:20. Prior to starting this case, he relieved Defendant Johnson on a different case at 17:41 and finished that case at 18:23.
5/30/94	McMillan	McMillan billed Medicare for personally performing a case in OR-5 from 22:55 to 0:49. From 23:15 until 00:01, he was involved in a C-section in delivery room 1 on a different floor.

11/11/93	Boeke	Boeke billed Medicare for personally performing a case from 20:45 to 21:45 in OR-5. He did a different case in OR-18 from 21:45 to 23:06.
8/26/94	McMillan and Rice	McMillan billed Medicare for personally performing a case in OR-6 that started at 10:40. The case was turned over to Defendant Rice at 11:56. The CRNA time shows the case ended at 13:15, but apparently Defendant Rice was not present for emergence, since there is no MDA stop time charted. This seems likely since Defendant Rice started another case in OR-2 at 13:12 and finished it at 15:54. At any rate there were two concurrent cases going on at the same time and he was not allowed to bill for personally performing the case in OR-6.
12/28/94	Lang	Lang billed for personally performing a case in OR-1 from 7:28 to 10:30. He was doing another case in OR-4 from 8:13 to 10:09. The first case was therefore fraudulent. The record was altered to show that Defendant Reitz did the first case.

Location Defendant Abbott Northwestern Hospital

12/16/89	Beverlin and	Drew Mathews record shows this case lasted 2 hours and

	Dwarkanath	20 minutes. Beverlin started the case but was later relieved by Dwarkanath. In total, the two of them were present in the room for 25 minutes. The case was billed as AA.
1/18/95	Boening	Drew Mathews record shows this case lasted one hour. Boening was present for 20 minutes.
6/16/93	Burke	Drew Mathews record shows this case lasted one hour, but Burke was only present for 30 minutes, yet billed for personally performing the case.
12/3/92	Gayes and Burke	Drew Mathews record shows this case lasted 3 hours and 10 minutes. Gayes started the case and was later relieved by Burke. Together the two of them were present for 25 minutes yet billed for personally performing the case.
11/28/95	Gayes	Drew Mathews records shows this case lasted 3 hours and 5 minutes, but Defendant Gayes never entered the operating suite but rather peered through the window of the adjacent ante-room occasionally during the case. He billed for personally performing the case. Clearly this was a non-medically directed CRNA case, and as such should have been billed using the QZ modifier.

		Instead the hospital routinely billed using the QX modifier (medically directed CRNA services) confirming the MDA fraudulent bill, even though this meant Medicare paid nothing or less than they should have for the CRNA services.
1/12/93	Gudman	Drew Mathews record shows this case lasted 2 hours and 35 minutes, but Defendant Gudman was present for only 35 minutes, yet he billed for personally performing the case.
8/13/93	Lillehei	Drew Mathews record shows this case lasted one hour and 18 minutes but Defendant Lillehei was present for only 25 minutes, yet he billed for personally performing the case.
9/1/93	McKlveen and Gudman	McKlveen started this case and was later relieved by Defendant Gudman. Drew Mathews record shows this case listed 8 hours, but Defendant McKlveen and Defendant Gudman were present for only one hour and 45 minutes, yet they billed for personally performing the case.

12/3/92	Menzel and Meisner	Menzel started this case and was later relieved by Defendant Meisner. Drew Mathews record shows this case lasted 3 hours and 30 minutes, but Defendant Menzel and Defendant Meisner were present for only 25 minutes, yet they billed for personally performing the case.
3/26/94	Musich and Lillehei	Musich started this case and was later relieved by Defendant Lillehei. Drew Mathews record shows this case lasted 2 hours and 10 minutes, but Defendant Musich and Defendant Lillehei were present for only 30 minutes, yet they billed for personally performing the case.
7/21/93	Plut	Drew Mathews record shows this case lasted 2 hours and 45 minutes but Defendant Plut was present for only 1 hour and 30 minutes, yet he billed for personally performing the case.
3/23/90	R. Johnson	Drew Mathews record shows this case lasted 2 hours, but Defendant Richard Johnson was present for only 50 minutes, yet he billed for personally performing the case.
10/3/94	Shaw, Boening, Beverlin	Shaw started this case and was later relieved by Defendant Boening, who was in

		turn relieved by Defendant Beverlin. Drew Mathews record shows this case lasted 2 hours and 15 minutes. Defendant Shaw was present for 16 minutes. Defendant Boening was present for 2 minutes. Defendant Beverlin was present for 7 minutes. They billed for personally performing the case.
5/23/95	Stauffer	Drew Mathews record shows this case lasted 2 hours and 40 minutes, but Defendant Stauffer was present for only 40 minutes, yet he billed for personally performing the case.
12/25/93	Wintermute	Drew Mathews record shows this case lasted 2 hours and 30 minutes, but Defendant Wintermute was present for only 1 hour and 5 minutes, yet he billed for personally performing the case.

Location North Memorial Hospital

3/31/91	Lader	Billed for personally performing procedure when he was absent from the room for a substantial period of time.
5/7/91	Walker	Billed for personally performing case when he was not in the room for the entire time.
4/25/91	Atmore	Billed for personally performing a case when he was not in

		the room for a substantial period of the time.
5/30/91	Lader	Billed for personally performing a case when he was absent from the room for a substantial period of time.
4/26/91	Everly	Billed for personally performing a case when he was absent from the room for a substantial period of the time.
5/9/91	Peterman	Billed for personally performing a case when he was absent from the room for a substantial period of the time.
9/27/94	Walker	Billed for personally performing a case when he was absent from the room for a substantial period of the time.
10/3/94	Peterman	Billed for personally performing a case when he was absent from the room for a substantial period of the time.

In addition, plaintiffs have in their possession printouts detailing the defendant, date, procedure, amount paid and other relevant information demonstrating that defendant Anesthesia P.A. during the relevant period submitted approximately 7,000 bills under the AA modifier. Plaintiffs intend to prove that in *all* of these cases, the Anesthesia, P.A. MDAs were absent from the room disqualifying them for reimbursement under Medicare. See Exhibit "A" hereto.

62. Defendent anesthesiologists were not merely momentarily absent from the operating room during the anesthesia procedures described above. Rather, during the relevant time period January 1988 to at least June 1996, it was routine for each of the defendant anesthesiologists to leave the operating room for substantial portions of the time that the procedure was taking place even though they intended to bill and did bill Medicare for personally performing the procedure occurring in the operating room. While the anesthesiologist was absent, it was the CRNA members of plaintiff MANA who actually provided the anesthesia services to the patient.

FALSE CLAIMS BASED UPON WRONG CONCURRENCY

63. The plaintiffs have also billed a substantial number of procedures with the wrong concurrency thereby inducing overpayments from Medicare. Some representative examples are the following:

Location Defendant Northwest Anesthesia

6/21/93	Beverlin	Billed for personally performing a procedure from 9:40 to 14:30 while concurrently involved in a procedure in another case from 7:15 to 10:05.
7/21/93	Beverlin	Billed for personally performing a procedure from 8:30 to 13:05 while concurrently involved in a procedure in another case from 7:15 to 8:55.

9/8/93	Beverlin	Billed for personally performing a procedure from 9:15 to 11:05 while concurrently involved in a procedure in another case from 7:30 to 11:00
11/9/93	Beverlin	Billed for personally performing a procedure from 14:30 to 19:40 while concurrently involved in a procedure in another case from 12:25 to 14:40.
11/25/93	Beverlin	Billed for personally performing a procedure from 10:20 to 18:02 while concurrently involved in a procedure in another case from 9:20 to 11:10.
12/23/93	Beverlin	Billed for personally performing a procedure from 8:30 to 11:40 while concurrently involved in a procedure in another case from 7:30 to 8:30.
7/25/94	Beverlin	Billed for personally performing a procedure from 9:55 to 16:40 while concurrently involved in a procedure in another case from 8:20 to 10:40.
10/3/94	Beverlin	Billed for personally performing a procedure from 12:40 to 15:40 while concurrently involved in a procedure in another case from 11:30 to 13:30.
4/12/95	Beverlin	Billed for personally performing a procedure from 9:25 to 13:00 while concurrently involved in a procedure in another case from 7:40 to 14:40.

5/18/95	Beverlin	Billed for personally performing a procedure from 13:00 to 17:00 while concurrently involved in a procedure in another case from 11:25 to 14:15.
6/1/95	Beverlin	Billed for personally performing a procedure from 9:10 to 12:10 while concurrently involved in a procedure in another case from 8:00 to 10:30.
12/15/95	Beverlin	Billed for personally performing a procedure from 15:20 to 18:10 while concurrently involved in a procedure in another case from 14:20 to 16:05.
8/8/93	Blomberg	Billed for personally performing a procedure from 10:35 to 13:50 while concurrently involved in a procedure in another case from 10:20 to 12:30.
11/11/93	Blomberg	Billed for personally performing a procedure from 14:40 to 19:00 while concurrently involved in a procedure in another case from 13:00 to 14:40.
2/10/94	Blomberg	Billed for personally performing a procedure from 16:05 to 20:30 while concurrently involved in a procedure in another case from 13:10 to 16:20.
11/18/94	Blomberg	Billed for personally performing a procedure from 15:07 to 19:50

		while concurrently involved in a procedure in another case from 14:00 to 15:35.
1/24/95	Blomberg	Billed for personally performing a procedure from 11:03 to 14:10 while concurrently involved in a procedure in another case from 7:35 to 11:30.
2/8/95	Blomberg	Billed for personally performing a procedure from 8:40 to 9:10 while concurrently involved in a procedure in another case from 7:30 to 9:05.
4/20/95	Blomberg	Billed for personally performing a procedure from 10:30 to 14:00 while concurrently involved in a procedure in another case from 8:05 to 10:30.
6/9/95	Blomberg	Billed for personally performing a procedure from 11:20 to 16:10 while concurrently involved in a procedure in another case from 7:40 to 13:15.
10/3/95	Blomberg	Billed for personally performing a procedure from 8:50 to 15:25 while concurrently involved in a procedure in another case from 7:35 to 8:50.
6/24/93	Boening	Billed for personally performing a procedure from 10:25 to 13:30 while concurrently involved in a procedure in another case from 10:00 to 11:45.

8/18/93	Boening	Billed for personally performing a procedure from 9:35 to 14:35 while concurrently involved in a procedure in another case from 7:30 to 9:50.
11/17/93	Boening	Billed for personally performing a procedure from 8:10 to 11:20 while concurrently involved in a procedure in another case from 7:25 to 10:15.
4/6/94	Boening	Billed for personally performing a procedure from 8:30 to 9:50 while concurrently involved in a procedure in another case from 7:15 to 9:00.
7/23/94	Boening	Billed for personally performing a procedure from 12:10 to 13:05 while concurrently involved in a procedure in another case from 7:50 to 12:10.
8/21/94	Boening	Billed for personally performing a procedure from 17:45 to 19:45 while concurrently involved in a procedure in another case from 16:45 to 17:35.
10/11/94	Boening	Billed for personally performing a procedure from 11:55 to 13:15 while concurrently involved in a procedure in another case from 10:50 to 12:22.
1/21/96	Boening	Billed for personally performing a procedure from 21:40 to 0:55 while

		concurrently involved in a procedure in another case from 20:50 to 22:45.
6/16/93	Burke	Billed for personally performing a procedure from 11:35 to 18:50 while concurrently involved in a procedure in another case from 10:35 to 12:10.
6/17/93	Burke	Billed for personally performing a procedure from 10:50 to 12:55 while concurrently involved in a procedure in another case from 10:35 to 12:55.
1/3/94	Burke	Billed for personally performing a procedure from 9:05 to 12:10 while concurrently involved in a procedure in another case from 7:15 to 9:10.
10/17/94	Burke	Billed for personally performing a procedure from 9:35 to 12:55 while concurrently involved in a procedure in another case from 7:30 to 9:35.
10/26/94	Burke	Billed for performing a procedure from 9:10 to 10:35 while concurrently involved in a procedure in another case from 7:35 to 11:30.
10/31/94	Burke	Billed for performing a procedure from 9:55 to 11:35 while concurrently involved in a procedure in another case from 7:30 to 9:55.

11/17/94	Burke	Billed for performing a procedure from 20:50 to 22:30 while concurrently involved in a procedure in another case from 18:45 to 20:50.
2/20/95	Burke	Billed for performing a procedure from 9:12 to 13:20 while concurrently involved in a procedure in another case from 7:45 to 9:45.
9/27/95	Burke	Billed for performing a procedure from 9:50 to 13:12 while concurrently involved in a procedure in another case form 7:40 to 10:45.
7/30/93	Blomberg	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
10/28/94	Blomberg	Billed for personally performing a case from 15:00 to 16:15 when he was involved in a concurrent case from 12:15 to 15:00.
7/4/93	Boening	Billed for personally performing a procedure when she was involved in two concurrent procedures.
7/21/93	Boening	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.
8/9/94	Dwaraka-nath	Billed for performing a procedure from 9:00 to 13:30 while concurrently involved in a procedure in another case from 7:40 to 9:55.

9/8/94	Dwaraka-nath	Billed for performing a procedure from 10:20 to 12:40 while concurrently involved in a procedure in another case from 7:45 to 14:20.
6/16/93	Engwall	Billed for performing a procedure from 13:15 to 15:00 while concurrently involved in a procedure in another case from 13:10 to 13:40.
7/19/93	Gayes	Billed for performing a procedure from 11:45 to 16:45 while concurrently involved in a procedure in another case from 7:10 to 12:00.
7/23/93	Gayes	Billed for performing a procedure from 14:20 to 16:25 while concurrently involved in a procedure in another case from 13:25 to 14:45.
8/25/93	Giron	Billed for performing a procedure from 16:20 to 19:00 while concurrently involved in a procedure in another case from 16:10 to 17:30.
9/2/93	Groves	Billed for performing a procedure from 11:45 to 14:35 while concurrently involved in a procedure in another case from 10:40 to 11:50.
9/7/93	Gudman	Billed for performing a procedure from 9:15 to 11:10 while concurrently involved in a procedure in another case from 9:00 to 11:05.
9/2/93	Johnson	Billed for performing a procedure from 13:55 to 17:45 while concurrently involved in a procedure in another case from 7:00 to 15:30.

10/22/93	Johnson	Billed for performing a procedure from 14:15 and 19:45 while concurrently involved in a procedure in another case from 13:35 to 15:10.
12/8/93	Lilllehei	Billed for performing a procedure from 17:55 to 20:40 while concurrently involved in a procedure in another case from 16:25 to 18:20.
8/5/93	McKlveen	Billed for performing a procedure from 17:45 to 19:45 while concurrently involved in a procedure in another case from 17:00 to 18:15.
9/15/93	Meisner	Billed for performing a procedure from 12:15 to 14:00 while concurrently involved in a procedure in another case from 11:20 to 12:32.
4/29/94	Meisner	Billed for performing a procedure from 8:15 to 10:15 while concurrently involved in a procedure in another case from 8:00 to 9:15.
6/4/93	Menzel	Billed for performing a procedure from 9:50 to 13:30 while concurrently involved in a procedure in another case from 7:25 to 10:50.
10/19/93	Musich	Billed for performing a procedure from 11:45 to 14:45 while concurrently involved in a procedure in another case from 11:00 to 11:55.
10/22/93	Musich	Billed for performing a procedure from 23:00 to 3:30 while concurrently involved in a procedure in another case from 22:30 to 23:55.

8/26/93	Nissen	Billed for performing a procedure from 12:30 to 16:40 while concurrently involved in a procedure in another case from 12:15 to 14:40.
12/22/93	Nissen	Billed for performing a procedure from 15:10 to 17:00 while concurrently involved in a procedure in another case from 14:50 to 16:10.
7/12/93	Pereira	Billed for performing a procedure from 12:00 to 17:30 while concurrently involved in a procedure in another case from 7:35 to 12:25.
8/12/93	Pereira	Billed for performing a procedure from 9:45 to 14:45 while concurrently involved in a procedure in another case from 8:40 to 12:05.
9/9/93	Pereira	Billed for performing a procedure from 11:35 to 14:05 while concurrently involved in a procedure in another case from 10:10 to 16:30.
10/20/93	Pereira	Billed for performing a procedure from 20:10 to 21:55 while concurrently involved in a procedure in another case from 18:05 to 20:40.
8/23/93	Plut	Billed for performing a procedure from 12:25 to 14:55 while concurrently involved in a procedure in another case from 12:25 TO 13:25.
9/2/93	Plut	Billed for performing a procedure from 9:55 to 13:35 while concurrently involved in a procedure in another case from 9:15 to 11:20.

6/25/93	Shaw	Billed for performing a procedure from 8:00 to 8:35 while concurrently involved in a procedure in another case from 7:25 to 9:45.
11/4/93	Shaw	Billed for performing a procedure from 10:40 to 13:50 while concurrently involved in a procedure in another case from 9:40 to 11:15.
10/4/93	Skoog	Billed for performing a procedure from 18:20 to 23:05 while concurrently involved in a procedure in another case from 17:45 to 19:25.
10/28/93	Skoog	Billed for performing procedure from 10:00 to 16:45 while concurrently involved in a procedure in another case from 8:45 to 12:15.
7/21/93	Stauffer	Billed for performing a procedure from 11:00 to 12:15 while concurrently involved in a procedure in another case from 9:45 to 11:05.
11/5/93	Tiu	Billed for performing a procedure from 9:45 to 14:15 while concurrently involved in a procedure in another case from 7:20 to 10:15.
3/2/94	Tiu	Billed for performing a procedure from 10:25 to 14:20 while concurrently involved in a procedure in another case from 9:45 to 11:00.
8/6/93	Tronnier	Billed for performing a procedure from 17:00 to 21:45 while concurrently involved in a procedure in another case from 13:15 to 19:00.

6/22/93	Wintermute	Billed for performing a procedure from 11:10 to 15:00 while concurrently involved in a procedure in another case from 7:00 to 13:20.
3/21/94	Wintermute	Billed for performing a procedure from 11:30 to 14:20 while concurrently involved in a procedure in another case from 7:15 to 11:40.

Location Defendant Mercy Hospital

3/6/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/12/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/12/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/25/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/25/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/26/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.

3/11/92	Magdsick	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/18/92	Magdsick	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/25/92	Magdsick	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/17/92	Kloepper	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
1/14/92	Yue	Started a Medicare case at 10:50 and finished it at 11:50. The case was billed as though there were two concurrent cases, but he was involved in other cases from 11:30 to 12:30 and from 10:55 to 11:30.
3/18/92	Yue	Started a Medicare case at 9:05 and finished it at 10:20. The case was billed as though there were two concurrent cases but he was involved in other cases from 8:30 to 9:25, and from 8:40 to 11:30.
3/18/92	Yue	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.

3/23/92	Yue	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/23/92	Yue	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
3/25/92	Albay	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.
3/31/92	Janossy	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
1/28/92	Roseberg	Started a Medicare case at 12:07 and finished it at 13:10. The case was billed as though there were two concurrent cases, but he was involved in other cases from 11:45 to 14:15 and from 12:20 to 14:10.
3/6/92	Polta	Started a Medicare case at 7:30 and finished it at 11:20. The case was billed as though there were two concurrent cases, but he was involved in other cases from 7:35 to 8:00 and from 7:30 to 8:25.
3/30/92	Cumming	Started a Medicare case at 7:25 and finished it at 11:45. The case was billed as though there were two concurrent cases, but he was involved in other cases from 9:10 to 10:35 and from 7:30 to 11:45.

4/12/93	Baggen-stoss	Started a Medicare case at 11:55 and finished it at 15:00. The case was billed as though there were two concurrent cases but he was involved in other cases from 13:15 to 14:25, from 13:55 to 17:15 and from 14:50 to 17:20.

Location Defendant Unity Hospital

8/18/92	Albay	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.
9/24/92	Sperry	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
9/25/92	Polta	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
10/7/92	Hong	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
11/30/92	Albay	Billed for performing two concurrent procedures when he was involved in three concurrent procedures.
12/15/92	Heil	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.

7/23/92	Castillejos	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.
6/11/92	Castillejos	Billed for performing two concurrent procedures when she was involved in three concurrent procedures.

Location Defendant St. Cloud Hospital

11/3/93	Espelien	Billed QK indicating a concurrency of two for a case in OR-8 from 7:18 to 10:19. At the same time he was doing one case in OR-9 from 7:24 to 12:11 and another in OR-4 from 9:16 to 11:17. These cases should have been billed as a concurrency of three.
5/12/94	Reitz, Boyle, Halvorson	Reitz started a Medicare case in OR-9 at 7:40. At 9:00 he was relieved by one of his partners – either Boyle or Halvorson finished the case at 10:07. Initially the chart said Boyle took over the case, but the chart was altered to read that Halvorson took over the case instead. Boyle did other cases from 7:49 to 10:05 and from 9:15 to 9:40. Halvorson did other cases from 7:26 to 9:55 and from 10:03 to 11:44. Regardless who relieved Reitz, there were three concurrent cases, yet it was billed under Reitz's name as though there were only two concurrent cases.

5/6/94	Reitz, Boyle	Reitz started a Medicare case in R-4 at 7:51. At 11:26 Boyle took over the case and finished it at 12:02. Reitz was doing other cases from 7:25 to 10:30 and from 8:55 to 9:00. The case was billed under Reitz's name as though there were two concurrent cases, but in fact there were three.

FALSE CLAIMS ASSOCIATED WITH PAIN MANAGEMENT

64. In addition to the specific instances of fraud discussed above anesthesiologists practicing at St. Cloud, Unity, Mercy, North Memorial and Abbott Northwestern Hospitals have submitted false claims in connection with post-operative epidurals. Under Medicare regulations in force since at least 1992, anesthesiologists were not permitted to bill for epidurals which were performed during a general anesthesia and under no circumstances were they permitted to bill for daily management of an epidural on the date of the surgical procedure. In fact, the defendant anesthesiologists at St. Cloud Hospital, Unity and Mercy Hospitals violated this restriction and, nevertheless, submitted bills to Medicare. Between 1992 and the date of this Third Amended Complaint, it has been St. Cloud anesthesiology defendants' common practice to improperly stop the anesthesia time on the anesthesia record while the patient is still under anesthesia and the surgery has not yet been completed in order to place a post-operative epidural catheter. The purpose of stopping the anesthesia time on the record is to deceive Medicare into believing that the anesthesia procedure ended before the post-operative epidural was placed so that the doctor

may bill separately for the more expensive post-operative epidural. Between 1992 and the date of this Third Amended Complaint, defendants have on a number of occasions filed claims with Medicare which were improper and constituted false claims in connection with post-operative epidurals. In particular, by way of representative example, defendants filed the following claims on the following dates:

Date of Procedure Associated With False Claim	Defendant MDA	Summary of Procedure
Cases Billed Where The MDA Stopped The Anesthesia Time In Order To Separately Bill For Placement Of An Epidural		
Location Defendant St. Cloud Hospital		
11/2/93	Rajala	Rajala billed for personally performing a Medicare case in OR-5 from 7:40 to 14:40. The case was not finished until 15:05, but Defendant Rajala ended her time early in order to bill separately for placing an epidural catheter for post operative pain management. Since, by her own record, she was not involved in administering the general anesthetic of this case for the last 25 minutes, and did not participate in emergence, she was not entitled to bill for this case. In addition, she did the pre-operative evaluation of a patient for a case that started in OR-3 at 1330,

which would disqualify her from billing using the AA modifier.

		ACTUAL ANESTHESIA TIME	MDA TIME ABORTED TO BILL FOR EPIDURAL
5/1/93	Espelien	08:01-10:40	08:01-10:15
6/1/93	Lang	09:34-11:12	19:34-11:05
12/20/93	Zwick	07:26-10:50	17:26-10:29
12/29/93	Espelien	09:49-12:58	19:49-12:40
12/16/93	Boyle	09:38-12:10	09:38-11:45
12/16/93	Boeke	17:58-21:11	17:58-20:45
12/1/93	McMillan	09:20-13:20	09:30-12:58
12/1/93	Zwick	07:24-11:47	07:24-11:29

Other Cases Involving Improper Bills For Epidural Anesthesia

3/17/93	Boeke	Charged for more than four days of epidural management.
3/18/93	Boeke	Charged for more than four days of epidural management.
2/17/95	Boeke	Charged for more than four days of epidural management.
2/18/95	Boeke	Charged for more than four days of epidural management.
2/19/95	Boeke	Charged for more than four days of epidural management.

5/3/94	Boyle	Charged for more than four days of epidural management.
5/4/94	Boyle	Charged for more than four days of epidural management.
5/29/94	Boyle	Charged for more than four days of epidural management.
7/7/93	Boyle	Charged for more than four days of epidural management.
7/8/93	Boyle	Charged for more than four days of epidural management.
7/9/93	Boyle	Charged for more than four days of epidural management.
11/22/95	Boyle	Charged for more than four days of epidural management.
1/6/95	Espeland	Charged for more than four days of epidural management.
8/23/94	Espeland	Charged for more than four days of epidural management.
4/3/95	Espeland	Charged for more than four days of epidural management.
4/4/95	Espeland	Charged for more than four days of epidural management.
4/5/95	Espeland	Charged for more than four days of epidural management.
8/5/92	Espelien	Charged for more than four days of epidural management.
8/6/92	Espelien	Charged for more than four days of epidural management.

8/7/92	Espelien	Charged for more than four days of epidural management.
8/8/92	Espelien	Charged for more than four days of epidural management.
8/9/92	Espelien	Charged for more than four days of epidural management.
11/23/94	Espelien	Charged for more than four days of epidural management.
12/26/92	Evenson	Charged for more than four days of epidural management.
11/22/92	Evenson	Charged for more than four days of epidural management.
11/23/92	Evenson	Charged for more than four days of epidural management.
7/11/94	Gacusana	Charged for more than four days of epidural management.
12/2/95	Halvorson	Charged for more than four days of epidural management.
12/3/95	Halvorson	Charged for more than four days of epidural management.
12/4/95	Halvorson	Charged for more than four days of epidural management.
12/14/94	Halvorson	Charged for more than four days of epidural management.
6/22/94	C. Johnson	Charged for more than four days of epidural management.
12/6/95	C. Johnson	Charged for more than four days of epidural management.

12/7/95	C. Johnson	Charged for more than four days of epidural management.
12/8/95	C. Johnson	Charged for more than four days of epidural management.
12/9/95	C. Johnson	Charged for more than four days of epidural management.
12/10/95	C. Johnson	Charged for more than four days of epidural management.
12/11/95	C. Johnson	Charged for more than four days of epidural management.
12/12/95	C. Johnson	Charged for more than four days of epidural management.
12/13/95	C. Johnson	Charged for more than four days of epidural management.

In addition to the above representative examples, plaintiffs have a printout of approximately 87 pages listing similar claims by the St. Cloud defendants.

Defendant Anesthesia P.A.

4/1/92	Pizzaro	Charged for more than four days of epidural management.
4/7/93	Hoffman	Charged for more than four days of epidural management.
4/8/93	Hoffman	Charged for more than four days of epidural management.
9/6/92	Mazur	Charged for more than four days of epidural management.
1/20/92	Lader	Charged for 2 epidurals on the same day.

2/5/93	Lader	Charged for 2 epidurals on the same day.
8/4/93	Schultz	Charged for more than four days of epidural management.
8/5/93	Schultz	Charged for more than four days of epidural management.
8/6/93	Schultz	Charged for more than four days of epidural management.
8/7/93	Schultz	Charged for more than four days of epidural management.
8/8/93	Schultz	Charged for more than four days of epidural management.
8/9/93	Schultz	Charged for more than four days of epidural management.
3/11/95	Schultz	Charged for more than four days of epidural management.
3/12/95	Schultz	Charged for more than four days of epidural management.
3/13/95	Schultz	Charged for more than four days of epidural management.
3/14/95	Schultz	Charged for more than four days of epidural management.
3/15/95	Schultz	Charged for more than four days of epidural management.
9/4/93	Mont-gomery	Charged for more than four days of epidural management.
9/5/93	Mont-gomery	Charged for more than four days of epidural management.
8/30/93	Wright	Charged for more than four days of epidural management.

Defendant MAPA

8/12/92	Baggen-stoss	Charged for more than four days of epidural management.
8/14/92	Baggen-stoss	Charged for more than four days of epidural management.
8/15/92	Baggen-stoss	Charged for more than four days of epidural management.

DEFENDANT HOSPITALS' FRAUDULENT CONDUCT

65. The defendant anesthesiologists' general practices described above were based not on the interest of the patient or quality of care, but rather on maximizing defendant anesthesiologists' profits. For example, during the past six years the defendant anesthesiologists were invariably present for relatively simple billable procedures, such as placement of epidurals or arterial lines, but as set forth herein, are routinely absent for more crucial procedures such as (1) intubations (including emergency intubations), extubations in general anesthesia cases (in the case of Unity, Mercy and North Memorial anesthesiologists); (2) dosing and managing epidurals in labor cases; and (3) intubating and managing airways in trauma cases which are non-billable or have relatively low reimbursement value.

66. Furthermore, the defendants' practice of leaving the operating room for substantial periods of time is not motivated simply by the increased income that their false billing generates from Medicare, but also by the substantially increased compensation they can earn by improperly concurrently performing non-Medicare procedures which pay at a substantially higher rate. Indeed, Relator's

members have been informed by at least two separate individuals familiar with anesthesia billing practices that it would be impossible for the defendant anesthesiologists to obtain the annual compensation they make if they were, in fact, fulfilling the billing requirements of Medicare and accurately billing Medicare. At the defendant hospitals Medicare accounts for between 20%-30% of the procedures performed. Some of these procedures are lengthy and complex procedures such as open-heart procedures and craniotomies lasting up to 8 or 10 hours. If the defendant anesthesiologists actually performed those procedures as they have represented to Medicare they would be precluded from billing for any other procedure during that time period. In fact, as set forth herein, the defendant anesthesiologists in almost every case are involved in others activities, in many cases billable activities, at the same time as they have represented to Medicare that they are personally performing heart procedures, craniotomy procedures and other lengthy and complex procedures. As a result, plaintiffs are informed and believe that the defendant MDA anesthesiologists have obtained compensation far in excess of the national average and, in some cases, in excess of $500,000 per year. It is in order to maintain this improperly high level of compensation that the defendants have gone to the lengths that they have as described in this complaint to preserve their ability to submit false claims and to punish and chill the Relator's members who have sought to prevent or curb their fraudulent practices.

67. In addition to knowingly and actively aiding, abetting and facilitating defendant anesthesiologists' submissions of false claims and knowingly causing the Government to pay claims grounded in fraud as set forth

elsewhere herein and in the case of Unity and Mercy Hospitals profiting directly from that fraud, MANA is informed and believes that the defendant hospitals have themselves submitted false, misleading and inaccurate bills to Medicare which have resulted in overpayments by Medicare. In particular, in cases of medical necessity, defendant Abbott Northwestern, defendant Unity and Mercy and defendant St. Cloud have submitted bills seeking 100% reimbursement from Medicare on the basis that it was medically necessary for *both* a CRNA and an anesthesiologist to be involved in the case. Although the information concerning anesthesia time and services provided given to the hospital by the CRNAs was accurate, the hospitals billed the case under an improper modifier. As a result, Medicare paid both providers 100% of their qualified fee. In fact, in these cases the hospital knew that the anesthesiologists did not personally perform the case and that, in fact, there were not two providers involved in the case. Had the hospital correctly billed Medicare and advised the hospital that the doctors were not personally performing their cases, Medicare would only have been required to pay approximately 50% of the fee it actually paid. The hospitals also failed to bill for non-medical direction of a CRNA when there was either no MDA participation (cardioversions and MAC cases) or for participation which failed to meet minimal medical direction or personal performance requirements. To facilitate the inaccurate billings hospital medical records departments at Unity and Mercy would flag anesthesia records not signed by MDAs and required co-signing after the fact. This inaccurately led Medicare to assume participation by anesthesiologists and incorrectly identified the anesthesiologist billing for the procedure. Some representative examples at the defendant hospitals are the following:

Date of Procedure Associated With False Claim	Defendant MDA	Summary of Procedure Demonstrating MDA's Absence
Location Defendant Abbott Northwestern		
5/9/93	Dwarkanath	Drew Mathews record shows this open heart case lasted 3 hours and 15 minutes, but Defendant Dwarkanath was present for only one hour and 50 minutes, yet he billed for personally performing the case.
6/15/93	Lillehei	Drew Mathews record shows this case lasted 5 hours, but Defendant Lillehei was present for only 3 hours, yet he billed for personally performing the case.
3/3/93	Pereira	Drew Mathews record shows this case lasted 5 hours and 30 minutes, but Defendant Pereira was present for only 2 hours, yet he billed for personally performing the case.
1/25/90	Skoog and Meisner	Skoog started this case and was later relieved by Defendant Meisner. Drew Mathews record shows this case lasted 6 hours and 30 minutes, but Defendant Skoog and Defendant Meisner were present for only 4 hours and 5 minutes, yet they billed for

		personally performing the case.
11/12/92	Tiu	Drew Mathews record shows this case (repair of an aortic aneurysm) lasted 4 hours, but Defendant Tiu was present for only 1 hour and 20 minutes, yet he billed for personally performing the case.
10/1/90	Tronnier	Drew Mathews record shows this open heart case lasted 4 hours and 20 minutes, but Defendant Tronnier was present for only 2 hours and 30 minutes, yet he billed for personally performing the case.
6/22/93	Wintermute	Drew Mathews record shows this open heart case lasted 3 hours and 20 minutes, but Defendant Wintermute was present for only 1 hour and 45 minutes, yet he billed for personally performing the case.

Location Defendant Mercy Hospital

5/19/94	Sperry	Defendant Sperry billed for personally performing the anesthesia for placement of an arteriovenous shunt that started at 12:05 p.m. and ended at 1:30 p.m. Defendant Sperry was doing other cases as follows: (1) 12:50 p.m. to 2:15 pm.; (2) 9:45 a.m. to 3:08

		p.m.; (3) 1:15 p.m. to 2:30 p.m.; and (4) 1:10 p.m. to 2:10 p.m. At 1:30 p.m. Defendant Sperry was involved in five concurrent cases and was not entitled to bill for either performing or medically directing the case. He could have billed for medical supervision and received a fee appropriate for his involvement. In addition, this simple procedure is not among the CPT codes accepted by the local Medicare carrier as "medically necessary" for two providers. This case occurred after CRNAs were forced to subcontract with the anesthesiologists if they wanted to still work at Mercy Hospital. Health Billing Systems submitted both Defendant Sperry's bill for personally performing the case and a bill for the subcontracted CRNA's services.
Location Defendant Unity Hospital		
8/19/94	Eggen	Billed for personally performing a case from 11:45 a.m. to 1:55 p.m. while performing a case from 1:30 p.m. to 3:00 p.m. Health Billing Systems submitted a bill for Defendant Eggen using the AA modifier and a CRNA bill for the same case.

9/20/94	Ryberg	Billed for personally performing a case from 11:35 a.m. to 1:55 p.m. while performing a case from 10:50 a.m. to 12:25 p.m. Health Billing Systems submitted a bill for Defendant using the AA modifier and a CRNA bill for the same case.
9/27/94	Maggs	Billed for personally performing a case from 11:25 a.m. to 2:15 p.m. while performing another case from 1:25 p.m. to 3:00 p.m. Health Billing Systems submitted a bill for Defendant Maggs using the AA modifier and a bill for the CRNA subcontractor for the same case.

Information regarding defendant St. Cloud is not in MANA's possession. However, plaintiff is informed and believes, based upon its members' knowledge of billing practices at that hospital, that similar bills were submitted by the hospital for medical necessity where MANA members know there were not two anesthesia providers present for the entire procedure. The specific dates and patients' names will appear on those bills which are currently only in defendant St. Cloud's possession.

CONDUCT EVIDENCING FRAUDULENT INTENT

68. The defendant hospitals and anesthesiologists defendants have engaged in conduct in furtherance of the above-referenced fraud for purposes of either concealing

the fraud or perpetuating it. Examples of this conduct include:

(1) On a substantial number of occasions, MAPA defendants at Unity and Mercy Hospitals changed circles on the anesthesia record which correctly reflected the concurrency of the cases they were billing to a lower number which misrepresented the true concurrency of the case.

(2) It was a frequent practice for the call MDA to go through previous days records and make changes to the circles.

(3) Defendant Castillejos was seen circling numbers on stacks of anesthesia records at the end of the day which had not been circled by the anesthesiologist in charge of the case. Defendant Magdsick on a number of occasions was seen by Annette Atchison to circle concurrency the following day on cases by other MDAs. On information and belief defendant Castillejos and Magdsick had no knowledge that the circles that they were entering were accurate. This was further confirmed when defendant Heil stated to a Unity CRNA, Maureen Merriam, that defendant Al Tank, MAPA's billing person, said they should be billing a lot more 1:1 and stated to Marie Parvie, one of the Mercy CRNAs, that defendant Al Tank had told her that they were "entitled to bill" about 50% of their cases 1:1. Castillejos also stated to Maureen Merriam that Al Tank was "upset" because Catillejos was not circling enough cases as 1:1.

(4) The MAPA defendants made no attempt to put times on electroconvulsive therapy or pain management records thereby precluding Medicare from determining whether their involvement in those procedures would

have disqualified them from billing Medicare for personally performing concurrent procedures.

(5) Defendant Sperry stated to Maureen Merriam that Medicare will not penalize me "if I do a small case during a 1:1 and bill Medicare for personally performing a 1:1.

(6) In or about April 1991 or 1992 on a weekend in connection with *four* consecutive fractured hip cases for Medicare patients, defendant Rydberg circled a 1 on each record although he was not in the operating room for the majority of the procedure and was, in fact, up in OBGYN on another floor giving epidurals or engaged elsewhere in the hospital. The specific date and times of these false claims can be determined by reviewing the billing records for the relevant period which are exclusively in defendants' possession at this time.

(7) Defendant Craig Johnson at St. Cloud and defendants Mark Sperry and John Magdsick at Unity and Mercy and defendant Mark Nissen at Abbott Northwestern all stated at different times that they did not intend to lose a single penny as a result of changing reimbursement policies and would take whatever steps were necessary to ensure that this occurred.

(8) Defendant Al Tank stated on repeated occasions to CRNAs, including to Fred Benjamin, Mary Buchman, Faye Leatherman, Kaye Vaske and others that he kept multiple sets of books, one for the government, one for the hospital and one for the doctors. Al Tank also told MANA member Fred Benjamin that he had a special way of billing that nobody else could do which would maximize the anesthesiologists' bills. Defendant Sperry told Annette Atchison, CRNA they had special ways of hiding the

profits made by CRNAs, and told Mary Jo Krauel he was going to have to remember which lies he told to whom. Defendant Al Tank made no attempts to confirm whether the anesthesiologist doctors for which he was submitting bills were following Medicare regulations. MAPA defendants made no attempt to determine whether or not their billing persons, Al Tank and Carol Kolbinger, were appropriately following Medicare regulations.

(9) The MAPA defendants, despite the use of an expensive software program to determine concurrencies, consistently submitted incorrect bills to Medicare between 1992 and 1994 resulting in most cases in over payments to MAPA. When the law was changed in January 1994 to provide that supervising additional concurrent procedures would not reduce the anesthesiologist's fee, these errors decreased substantially.

(10) Ladonna Schweer and Terry Rozinka repeatedly asked to see Medicare Denials at Unity and Mercy to appeal those which were incorrect, but the hospitals refused to allow the CRNAs to review them. When Chuck Hauwiller and Drew Mathews began documenting MDA presence in the room during a case, they received a warning from the hospital and the defendants MDAs to stop.

(11) Even though CRNAs at St. Cloud, Unity, Mercy and Abbot Northwestern presented records to each of those defendant hospitals showing not only that the doctors were not present at key times during procedures they had billed but, in fact, that those doctors were in other operating rooms. The hospitals refused to seek a change in the practice of the doctors in their hospitals or to directly address the doctors' proven fraudulent billing.

(12) At all times, defendant hospitals have been or should have been aware that defendant anesthesiologists were presenting false claims to Medicare. Rather than taking steps to prevent the fraud, however, Defendant hospitals have knowingly aided, abetted and facilitated it.

(13) In 1990, Faye Leatherman confronted one of the MDAs who was circling the wrong number for concurrencies on the anesthesia record, she was told to mind her own business.

(14) Between 1990 and 1994, Bart Barry, a CRNA hospital employee, was circling the correct concurrencies on the anesthesia records in which he was involved. He was told by both defendant Sperry and defendant Janossy to stop circling the numbers.

(15) Ladonna Schweer told Judy Haviland and John Murphy, both Operations Vice Presidents of Unity and Mercy, and Dan Roach, corporate counsel, that the Unity and Mercy anesthesiologists were not personally performing cases and were billing for cases when they were in other operating rooms. The hospital took no steps to stop this practice.

(16) Lisa Citak, a CRNA at Abbott Northwestern, repeatedly reported that the doctors were fraudulently billing to hospital personnel but received no response other than blanket denials that fraudulent billing was occurring.

(17) At defendant St. Cloud, Sandra Henschke, Jerry Boldon and other CRNAs reported directly their belief that the defendant doctors were fraudulently submitting bills since the CRNAs were performing the services

and the doctors were in other operating rooms. St. Cloud Hospital took no action to address this fraud.

(18) John O'Konek, a CRNA at Unity, and Bart Barry, a CRNA at Mercy, observed on a number of occasions defendant anesthesiologists in the hospital were covering four to five concurrent procedures. The specific times and dates of these procedures are not available at this time but can be discovered through review of the appropriate anesthesia records in possession of the defendants. It was a common practice for anesthesiologists to start cases and turn them over to MDAs who were already responsible for 2-3 room. Documentation on the anesthesia record or billing, did not reflect these changes.

(19) In a case involving Faye Leatherman when she was a student at Abbott Northwestern, defendant Pereira left Leatherman alone in the room with an extremely difficult heart surgery. Leatherman paged Pereira on multiple occasions and Pereira failed to respond. Later when the patient was taken to PACU a comment was made by the PACU nurse when she learned that Pereira had failed to respond that the patient must have been a Medicare patient. Chuck Hauwiller repeatedly paged for assistance with a patient who was hemorrhaging, but defendant Rick Johnson failed to respond. In a recent case at Abbott Northwestern, Pereira followed his general practice of failing to frequently monitor the case and failing to respond to pages. As a result of Pereira's failure to respond to pages, his giving inappropriate telephone orders given without being present to assess the patient, and creating an environment where CRNAs are restricted, the patient died. This incident, unbeknownst to MANA or its members, was reported by a non-CRNA to the Department of Health. The Department of Health independently

investigated the incident on behalf of HCFA and concluded that Abbott Northwestern was deficient in several areas of anesthesia, including: 42 C.F.R. 482.12(a) Medical Staff (A022), 42 C.F.R. 482.21(a) Clinical Plan (A054); 42 C.F.R. 482.52(a) Organization and Staffing (A264); 42 C.F.R. 482.52(b) Delivery of Services (A279). In connection with these findings, HCFA noted (a) it was reported and verified by interview that some anesthesiologists failed to appropriately respond to their pagers; (b) that delay of reviews of quality assurance matters in the anesthesia department for five months were not unusual; (c) that student registered nurse anesthetists were allowed by the hospital and the MDAs to provide anesthesia without being under the direct supervision of a CRNA or an MDA; (d) that a record review revealed at least two occasions where the only signature of an anesthesia provider on the record was a student anesthetist; (e) that an MDA interviewed by HCFA admitted that he routinely responded late to pages to the PACU; and (f) that documentation revealed that the MDA defendants in this case did not always assist with the transport of ASA-4 patients to the PACU.

The foregoing findings corroborate the allegations of this complaint and demonstrates the hospital's unwillingness to address concerns brought to its attention by the CRNAs. Further proof of the hospital's complicity in this fraud is its attempt to cover up the investigation by intimidating CRNA witnesses and attempting to blame the whole incident on the CRNAs involved rather than investigating and appropriately sanctioning the MDA responsible for the case.

(20) At Abbott Northwestern, defendant Boening, twice in the space of a month, left a patient unattended in a surgery with no CRNA and no MDA present.

On the first occasion, defendant Boening relieved a CRNA responsible for the case and told her to go to lunch and then Boening left the room. The CRNA discovered Boening outside the operating room when she returned from lunch. In the second case, the CRNA was Curt Pascoe. Boening instructed him to go obtain medication from a locked medicine cabinet. When Pascoe returned, Boening was sitting talking on the telephone outside the operating room and there was no anesthesia provider in the room with the patient and the surgeon.

(21) Defendant Albay was discovered sleeping during a case by Fred Benjamin, the CRNA involved with the case. Defendant Baggenstoss appeared to have been sleeping during a case involving Bart Barry.

(22) Maureen Merriam repeatedly observed that MDAs were sleeping at night during cases for which she was the responsible CRNA and yet marking that they personally performed the case on the record.

(23) In a case involving Bart Barry, on which defendant Maggs was the responsible anesthesiologist which occurred during the relevant time period to the complaint, Maggs was watching a movie and did not respond when paged by Barry. Maureen Merriam was unable to get defendant Maggs to respond to an unstable patient because he was on the phone with his wife about a charity ball.

(24) Many of the anesthesiologists at Unity and Mercy Hospital owned beepers but intentionally did *not* carry them with them when they were at the hospital. In 1993, Bart Barry twice stat paged defendant Roseberg to

the OR and never responded. Annette Atchison paged defendant Magdsick several times at the surgeons request and he did not respond. Defendant Suh did not respond to a page from Bart Barry when his patient undergoing heart surgery was coming off bypass. A patient which defendant Castillejos was responsible for died in the preoperative holding area while she was in the Doctor's Lounge next door. Because of this reported lack of response, Ladonna Schweer raised the issue that the Unity and Mercy MDAs do not carry beepers but the hospital refused to require them to do so.

(25) CRNAs at Mercy, Abbott Northwestern, St. Cloud and North Memorial were told by the defendant anesthesiologists that it was the general practice for anesthesiologists at those hospitals to bill heart cases on a 1:1 basis. At Abbott Northwestern an inordinately large percentage of the cases performed are heart cases. In 1994, as a result of what they perceived to be changes in Medicare billing reimbursement policies, the Abbott Northwestern MDAs unilaterally announced that they were going to take over four of the eight operating rooms reserved for hearts and would refuse to allow CRNAs to be involved in those cases. This decision was admitted to be based solely upon economics and was unrelated to quality of care concerns.

(26) In fact, after they assumed control over the heart rooms, the defendant anesthesiologists utilized student nurse anesthetists to perform procedures in those rooms and continued routinely to leave the room, leaving the only anesthesia provider in the room an inexperienced student CRNA.

(27) None of the anesthesiologist defendants documented the services they were providing in an appropriate manner to satisfy Medicare regulations. In particular, none of the anesthesiologists signed in and out of the room when they left the room; none of them documented on the anesthesia chart that they had personally participated in emergence; they very rarely documented when another anesthesiologist assumed the case or relieved them on a case; and they failed to appropriately document concurrent procedures performed by them during Medicare cases. At best, the foregoing showed a complete disregard for the Medicare billing requirements and the needs of their patients. At worst, the foregoing demonstrates an intentional and organized effort to deceive Medicare and to provide Medicare and relator of appropriate records to prove defendants' fraudulent conduct.

HARASSMENT AND INTIMIDATION OF CRNAS WHO REPORTED THE FRAUD OR ASSISTED THIS ACTION

69. The False Claims Act specifically provides for protection for CRNAs who report false claims or assist in prosecution of a false claims action. Following are examples of attempts to intimidate the principal witnesses in the case against the defendants and further demonstrate defendant anesthesiologists' and hospitals' complicity:

a. When defendant Boeke was personally served with a copy of the Summons and Complaint in a related antitrust action alleging fraud on behalf of the doctors, he stated referring to the plaintiffs in the case, "They're dead, they're dead."

b. Plaintiff Ladonna Schweer has had both the passenger window of her car shattered and the hood of her car dented while it was parked in the Unity and Mercy parking lot. These actions occurred subsequent to defendant John Murphy requesting that security provide him with the identify of and license plate number of Ladonna Schweer's car.

c. An unknown individual illegally entered into the locker of Steve Milliken, a CRNA who has provided evidence in connection with this case, and cut the tongue of out of one of his shoes. On information and belief the only individuals who would have access to the identity and combination of Steve Milliken's locker would be the defendant MDAs or the defendant Abbott Northwestern Hospital.

d. CRNA Lisa Citak who reported fraud at Abbott Northwestern was approached by defendant Meredith during an anesthesia procedure who made veiled threats about Citak's ability to support her husband (who is severely ill) and family if the plaintiffs continued to pursue this lawsuit.

e. Anesthesiologists at various of the defendant hospitals made statements to CRNAs to the effect that by pursuing reimbursement for billing for anesthesia procedures the CRNAs had stuck their heads out of a fox hole and were getting them shot off. This was specifically said by Defendant Baggenstoss to Ladonna Schweer at Unity and Mercy Hospital, then by defendant Sperry to John O'Konek and by defendant Kleopper to Maureen Merriam.

f. When Ladonna Schweer complained about the MAPA defendants' fraudulent billing to officers at Unity and Mercy Hospitals, she was repeatedly told to "remember

where your paycheck comes from." This statement was specifically made to her by John Murphy, Operations Vice President of Unity and Mercy Hospitals.

g. When the MDAs learned that Chuck Hauwiller, a CRNA at Abbott Northwestern, was recording when they were absent from the operating room and absent at emergence, defendant Johnson, President of defendant Northwest Anesthesia, wrote a memo instructing him to stop doing so. When he refused to do so, the hospital, in complicity with the MDAs, called Hauwiller into a meeting where direct and indirect threats to his employment were made if he did not stop making notations on the anesthesia record.

70. Among other things, Defendant hospitals have knowingly (1) permitted defendant anesthesiologists to bill in a manner which impedes discovery of their false claims; (2) refused to require defendant anesthesiologists to sign in and out of operating rooms; (3) In the case of Unity and Mercy, refused to require defendant anesthesiologists to carry "pagers"; (4) ignored and discouraged complaints by Relator's members concerning the anesthesiologists' false and fraudulent billing practices; (5) denied CRNAs who had signed over their billing rights to the hospitals, access to Medicare denials for review and appeal; and (6) in the case of defendants Unity, Mercy, Abbott Northwestern and St. Cloud, retaliated against Relator's members for reporting such fraud. Defendant hospitals did not appropriately bill using a non-directed CRNA modifier when they knew the anesthesiologists were not participating in some procedures and not meeting minimal medical direction or personal performance requirements in others. Instead, they allowed – and expected MDAs to come to medical records and sign cases they were not involved in. This

practice resulted in Medicare paying almost twice as much.

71. Most notably, after CRNAs (members of Relator) at defendants Unity and Mercy Hospitals reported to those hospitals (including directly to defendant Murphy) and produced to them records documenting instances of fraudulent billing by anesthesiologist defendants, those hospitals, in concert with the anesthesiologists, fired the CRNAs and pressured them to become employed by the anesthesiologists.

72. Essentially the same scenario unfolded at defendant St. Cloud Hospital. In 1992, CRNA supervisors on behalf of the entire staff wrote and verbally complained about the fraudulent billing. Thereafter, they were first downgraded from medical associates to medical assistants and then fired and coerced to work for the defendant St. Cloud anesthesiologists.

73. The hospital defendants were motivated in the concerted action by (1) the desire to permit the anesthesiologists to continue their fraudulent billing practices; and (2) the desire of the hospitals to avoid confrontation with the anesthesiologists over – but simultaneously to distance themselves from – the anesthesiologists' fraud. The firing by the hospitals and rehiring by the anesthesiologists of the CRNAs was calculated to accomplish these purposes by giving the anesthesiologists sole control over billing for all anesthesia services – whether performed by the MDAs themselves, by CRNAs themselves, or by a combination of the two – thereby eliminating the risk that CRNAs would continue to expose the anesthesiologists' fraud by submitting to Medicare and others separate bills belying the fraudulent bills submitted by the anesthesiologists.

74. Relator is informed and believes that the global elimination of CRNAs as employees of the hospitals and use of economic coercion, including severance pay, to compel the CRNAs to be employed by defendant anesthesiologists was planned and coordinated by defendants. In addition, St. Cloud, Unity, Mercy and Abbott Northwestern hospitals coordinated the termination of CRNAs and exchanged information between themselves in order to facilitate this result for the benefit of MDAs. In order to conceal what defendant hospitals knew to be facilitation of defendant anesthesiologists' billing fraud, defendants engineered a pretext whereby defendants claimed that various of defendant hospitals were losing money on CRNAs when, in fact, those hospitals own records demonstrate that the CRNA employees were profitable. Defendant hospitals were also motivated by their desire to perpetuate an even wider fraud on the insurance companies and citizens of Minnesota which would actually increase the cost of anesthesia to patients and insurers rather than decrease it.

ENORMITY OF DEFENDANTS' FRAUD

75. It is estimated that between 1988 and the date of this Third Amended Complaint, defendant anesthesiologists collectively submitted in excess of 100,000 individual false claims for time-billed procedures to Medicare for services performed at their hospitals and received at least $13 million. Relators currently have information supporting the conclusion that by the end of 1994 defendants had submitted approximately 88,000 false claims. Relator is informed and believes these claims were false or fraudulent claims under Section 3729 because they did not satisfy one or more of the requirements for reimbursement.

Furthermore, MANA is informed the defendants' fraud is continuing and ongoing as of the date of this Third Amended Complaint.

76. Defendants are liable under 31 U.S.C. §§3729 and 3730 for (a) penalties in the maximum amount of Ten Thousand Dollars ($10,000.00) for each of these approximately 100,000 claims or One Billion Dollars ($1,000,000,000), plus (b) three times the amount of damages which the Government has sustained as a result of defendants' false claims which plaintiffs estimate to be approximately $39 million.

COUNT ONE

77. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 76 as if the same were set forth herein.

78. As more particularly set forth in the forgoing paragraphs, both defendant anesthesiologists and defendant hospitals have knowingly presented, or caused to be presented, to officers or employees of the United States Government, false or fraudulent claims for payment or approval in violation of 31 U.S.C. §3729(a)(1).

COUNT TWO

79. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 78 as if the same were set forth herein.

80. Defendant anesthesiologists and hospitals have knowingly made, used, or caused to be made or used, false records or statements to get false or fraudulent claims

paid or approved by the Government in violation of 31 U.S.C. §3729(a)(2).

COUNT THREE

81. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 80 as if the same were set forth herein.

82. Defendant hospitals and anesthesiologists and their defendant agents have conspired to defraud the Government by obtaining or seeking to obtain allowance and payment of false or fraudulent claims allowed or paid in violation of 31 U.S.C. §3729(a)(3).

COUNT FOUR

83. Plaintiff repeats and realleges the allegations contained in paragraphs 1 through 82 as if the same were set forth herein.

84. Defendant hospitals and anesthesiologists and their defendant agents have knowingly made, used, or caused to be made or used, false records of statements to conceal, avoid, or decrease obligations to pay or transmit money or property to the Government in violation of 31 U.S.C. §3729(a)(7).

COUNT FIVE

85. In addition to the misconduct described in the foregoing Counts, defendant hospitals have violated their obligations under their provider agreements with Medicare and have further conspired with defendant

anesthesiologists to submit false and/or fraudulent claims to the United States Government.

WHEREFORE, on behalf of the United States Government, Relator demands judgment against each of the above-named defendants, jointly and severally, as follows:

a. That by reason of the violations of the False Claims Act as set out in the First through Fourth Causes of Action, this Court enter judgment against Defendants in an amount up to Three (3) times the amount of damages the United States Government has sustained because of Defendants' actions, plus a civil penalty of not less than Five Thousand Dollars ($5,000.00) and not more than Ten Thousand Dollars ($10,000.00) for each separate claim which constitutes a violation of 31 U.S.C. §3729;

b. That Relator as *Qui Tam* Plaintiff be awarded the maximum amount allowed pursuant to Section 3730(d) of the False Claims Act and/or any other applicable provision of law;

c. That Relator be awarded all costs of this section, including attorneys' fees and court costs;

d. That Relator be awarded its expenses in connection with this action pursuant to 31 U.S.C. Section 3729.

e. That appropriate injunctive relief pursuant to 31 U.S.C. §3730(h) be awarded to Relator's members and others who have taken or may take lawful action in furtherance of this Complaint; and

f. That Plaintiff and the Relator receive such other and further relief as the Court may deem to be just and proper.

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Attorneys for Plaintiffs

Dated: March 20, 1997

TRIAL BY JURY

Plaintiffs hereby demand a trial by jury as to all issues.

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Dated: March 20, 1997

EXHIBIT "A"

The attached Exhibit is based upon partial information concerning the bills submitted to Medicare by the defendant anesthesiologists during the relevant time period. The numbers contained in the Third Amended Complaint are based upon Relator's estimation of the total number of bills actually submitted. The total number of false claims for which plaintiffs have documentation is approximately 88,000 as set forth herein. However, the schedule does not include fraudulent bills for medical direction submitted by the St. Cloud and Abbott Northwestern anesthesiologists and further does not include bills for medical direction from Unity, Mercy, North Memorial and Abbott Northwestern from 1994 to date.

Total Paid AA Cases	95% Total Paid AA Cases	Total Cases AA	95% Total Cases AA	Total Fraudulent Payments	Total Penalties
Summary for Provider = 059000456-Boeke, Gary (1574 detail records)					
$132,954.86	$128,310.27	613.00	487.35	$128,310.27	$4,873,500
Summary for Provider = 059000457 – Boyle, Phillip (1383 detail records)					
$158,739.35	$153,831.91	613.00	582.35	$153,631.91	$5,823,500
Summary for Provider = 059000458 – Espeland, Lee (1973 detail records)					
$31,584.98	$31,124.99	178.00	170.05	$31,124.99	$1,700,500
Summary for Provider = 059000459 – Espelien, Alan (1374 detail records)					
$79,963.38	$77,432.72	496.00	471.20	$77,432.72	$4,712,000
Summary for Provider = 059000460-Evenson, Curtis (525 detail records)					
$58,572.71	$57,933.89	220.00	209.00	$57,933.98	$2,090,000
Summary for Provider = 059000461 – Gacusana, Joseph (693 detail records)					
$35,816.73	$34,943.30	232.00	220.40	$34,943.30	$2,204,000
Summary for Provider = 059000462 – Halvorson, Paul (1835 detail records)					
$100,142.53	$97,153.66	438.00	416.10	$97,153.66	$4,161,000
Summary for Provider = 059000463 – Johnson, Craig (1429 detail records)					
$122,589.13	$118,419.89	486.00	461.70	$118,410.99	$4,617,000
Summary for Provider = 059000464 – Johnston, Dan (213 detail records)					
$23,446.50	$22,884.24	107.00	101.65	$22,884.24	$1,016,500

Summary for Provider = 059000465 – Lang, Lance (1041 detail records)					
$80,265.08	$76,840.11	364.00	345.80	$76,840.11	$3,458,000
Summary for Provider = 059000466 – McMillan, Alan (956 detail records)					
$71,117.84	$67,561.97	330.00	313.50	$67,561.97	$3,135,000
Summary for Provider = 059000467 – Rajala, Mary (282 detail records)					
$13,635.38	$12,953.62	81.00	74.85	$12,953.62	$769,500
Summary for Provider = 059000468 – Reitz, Alan (800 detail records)					
$56,632.51	$53,800.88	247.00	234.65	$53,800.88	$2,346,500
Summary for Provider = 059000469 – Rice, William (1648 detail records)					
$76,318.16	$73,762.10	486.00	442.70	$73,762.10	$4,427,000
Summary for Provider = 059000471 – Zwick, Annette (906 detail records)					
$73,251.13	$69,588.57	289.00	274.55	$69,588.57	$2,745,500
Summary for "FAC" = AASC (16459 detail records)					
$1,114,829.11	$1,076,342.34	5,061.00	4,807.95	$1,078,342.34	$48,079,500

Total Paid AA Cases	95% Total Paid AA Cases	Total Cases AA	95% Total Cases AA	Total Paid Medically Directed Cases	95% Total Paid Medically	Total Medically Directed Cases	95% Total Medically Directed Cases	Total Fraudulent Payments	Total # Fraudulent Cases	Total Penalties
Summary for Provider = 050000172 – Pizarro, Remi (725 detail records)										
$73,982.41	$23,758.84	112.00	106.40	$52,111.04	$51,774.46	614.00	583.30	$75,533.30	489.70	$6,897,000
Summary for Provider = 050000173 – Everly, Stephen (444 detail records)										
$21,571.17	$21,409.47	108.00	102.60	$26,599.52	$26,361.25	336.00	319.20	$47,770.71	421.80	$4,218,000
Summary for Provider = 050000174 – Meredith, John (587 detail records)										
$24,623.68	$24,403.06	120.00	114.00	$43,885.38	$43,534.16	477.00	453.15	$67,937.22	567.15	$5,671,500
Summary for Provider = 050000175 – Hoffman, J (689 detail records)										
$33,371.38	$33,147.91	132.00	125.40	$43,431.58	$42,994.72	557.00	529.15	$76,142.63	654.55	$6,545,500
Summary for Provider = 050000176 – Mazer, Thomas (581 detail records)										
$28,154.90	$27,916.75	113.00	107.35	$37,804.57	$37,602.06	478.00	454.10	$65,518.81	561.45	$5,614,500
Summary for Provider = 050000177 – Lader, Steven (778 detail records)										
$33,608.92	$33,397.68	137.00	130.16	$47,289.77	$48,777.92	641.00	608.95	$80,175.80	739.10	$7,491,000
Summary for Provider = 050000178 – Petersen, Michael (743 detail records)										
$29,626.92	$29,331.49	147.00	139.65	$45,863.14	$45,509.20	598.00	566.20	$74,840.68	705.85	$7,058,500
Summary for Provider = 050000179 – Almore, William (710 detail records)										
$32,723.12	$32,461.54	149.00	141.56	$45,416.91	$45,091.99	561.00	532.95	$77,553.53	674.50	$6,745,000
Summary for Provider = 050000180 – Schultz, David (779 detail records)										
$31,023.96	$30,706.50	121.00	114.95	$42,255.14	$41,868.72	658.00	625.10	$72,595.30	740.05	$7,400,500
Summary for Provider = 050000181 – Montgomery, Michael (681 detail records)										
$33,462.05	$33,204.53	128.00	121.60	$41,386.05	$40,946.70	553.00	525.35	$74,151.23	646.95	$6,469,500
Summary for Provider = 050000274 – Benthall, Carolyn (25 detail records)										
$340.16	$334.56	3.00	2.85	$2,304.64	$2,258.89	22.00	20.90	$2,593.45	23.75	$237,500

Summary for Provider = 050000299 – Monehart, Daniel (803 detail records)										
$26,104.56	$25,934.87	104.00	98.80	$52,418.27	$51,953.97	699.00	684.05	$77,888.64	762.85	$7,628,500
Summary for Provider = 050000068 – Walker, Brian (626 detail records)										
$23,167.19	$23,006.33	107.00	101.85	$37,065.91	$36,609.60	519.00	491.05	$59,475.93	594.70	$5,947,000
Summary for Provider = 050000368 – Wright, Thomas (605 detail records)										
$23,082.62	$22,976.72	103.00	97.85	$36,313.40	$36,013.55	503.00	477.85	$58,990.26	575.70	$5,757,000
Summary for Provider = 060000434 – Larson, Loren (282 detail records)										
$3,748.46	$3,714.27	33.00	31.35	$18,587.87	$18,400.91	249.00	236.55	$22,115.18	267.9	$2,679,000
Summary for Provider = 060000550 – Schoenecker, Joan (117 detail records)										
$11,346.40	$11,278.68	58.00	53.20	$2,775.10	$2,754.54	61.00	57.95	$14,033.22	111.15	$1,111,500
Summary for Provider = 050000633 – Adkins-Finke, Bonnie (25 detail records)										
$2,839.42	$2,916.38	25.00	23.75	$0.00	$0.00	0.00	0.00	$2,916.38	23.75	$237,500
Summary for Provider = 050000654 – Hendricks, John (9 detail records)										
$1,847.34	$1,802.81	8.00	8.55	$0.00	$0.00	0.00	0.00	$1,802.91	8.55	$85,500
Summary for Provider = 061610845 – Anesthesiology, PA (201 detail records)										
$51,292.98	$50,909.76	201.00	190.95	$0.00	$0.00	0.00	0.00	$50,999.78	190.95	$1,908,500
Summary for Provider = 060000470 – Smith, Weston (1 detail record)										
$0.00	$0.00	0.00	0.00	$227.36	$215.99	1.00	0.95	$215.99	0.95	$9,500
Summary for "FAC" = Metro Anesthesia Network (9431 detail records)										
$1,358,646.97	$1,508,848.50	6,967.00	6,618.63	$1,417,339.97	$1,380,875.50	18,923.00	17,976.85	$2,889,674.00	24,525.50	$245,955,000

Total Paid AA Cases	95% Total Paid AA Cases	Total Cases AA	95% Total Cases AA	Total Paid Medically Directed Cases	95% Total Paid Medically	Total Medically Directed Cases	95% Total Medically Directed Cases	Total Fraudulent Payments	Total # Fraudulent Cases	Total Penalties
Summary for Provider = 050000071 – Metro Anesthesia Network (8706 detail records)										
$326,895.03	$321,830.29	1,661.00	1,577.95	$426,236.80	$416,736.22	5,046.00	4,793.70	$738,566.51	6,371.65	$63,716,500
Summary for Provider = 050000072 – Abbey, Thelma (393 detail records)										
$15,133.79	$14133.79	90.00	85.50	$26,337.07	$25,873.65	303.00	287.85	$40,480.58	373.35	$3,733,500
Summary for Provider = 050000073 – Baggenstoss, Gary (567 detail records)										
$32,876.84	$32,072.51	123.00	116.85	$31,848.02	$31,332.93	434.00	412.30	$63,405.44	529.15	$5,291,500
Summary for Provider = 050000074 – Castillejos, Minda (300 detail records)										
$9,607.68	$9,213.96	68.00	64.60	$18,886.80	$18,525.96	232.00	220.40	$27,738.93	285.00	$2,860,000
Summary for Provider = 050000075 – Cumming, James (730 detail records)										
$27,441.41	$26,909.02	151.00	143.45	$41,847.98	$41,116.35	579.00	550.05	$68,025.37	693.50	$8,935,000
Summary for Provider = 050000077 – Hong, Sang (620 detail records)										
$13,092.78	$12,663.57	95.00	90.25	$39,417.71	$38,799.49	525.00	496.75	$51,463.07	598.00	$5,890,000
Summary for Provider = 050000079 – Kloepper II, Raymond (691 detail records)										
$26,597.44	$25,798.78	155.00	147.25	$39,232.33	$38,543.05	536.00	509.20	$64,341.83	656.45	$6,584,500
Summary for Provider = 050000080 – Magdsick, John (531 detail records)										
$23,313.47	$22,537.81	112.00	106.40	$34,093.54	$34,051.99	419.00	396.05	$56,589.81	504.45	$5,044,500
Summary for Provider = 050000081 – Maggs, Thomas (480 detail records)										
$31,697.53	$30,485.92	142.00	134.90	$28,689.19	$28,120.85	338.00	321.10	$58,806.77	456.00	$4,560,000
Summary for Provider = 050000082 – Roseberg, John (546 detail records)										
$48,630.57	$47,124.74	180.00	171.00	$28,003.65	$27,507.97	368.00	347.70	$74,632.71	516.70	$5,187,000
Summary for Provider = 050000083 – Rydberg, John (351 detail records)										
$14,378.82	$13,865.89	104.00	98.80	$22,477.10	$22,130.78	247.00	234.65	$35,996.48	333.45	$3,334,500

Summary for Provider = 050000084 – Sperry, Mark (435 detail records)										
$22,389.03	$21,618.18	106.00	100.70	$27,173.98	$26,858.37	329.00	312.55	$48,273.53	413.25	$4,132,500
Summary for Provider = 060000085 – Suh, Jei (781 detail records)										
$31,248.85	$30,383.30	168.00	180.56	$44,827.64	$43,923.08	612.00	581.40	$74,306.38	741.95	$7,419,500
Summary for Provider = 050000324 – Potts, Thomas (518 detail records)										
$23,432.89	$22,658.67	113.00	107.35	$31,069.37	$30,484.36	406.00	385.70	$53,343.03	493.05	$4,930,500
Summary for Provider = 050000344 – Janossy, Theodore (393 detail records)										
$23,471.43	$22,783.61	106.00	100.70	$24,548.14	$24,164.13	287.00	272.65	$46,947.74	373.35	$3,733,500
Summary for Provider = 050000371 – Yue, Jeffrey (449 detail records)										
$24,556.08	$23,810.40	123.00	116.85	$22,939.05	$22,470.34	326.00	309.70	$46,280.74	426.55	$4,265,500
Summary for Provider = 050000386 – Heil, Teri (321 detail records)										
$18,107.92	$17,575.11	102.00	96.90	$15,455.32	$15,091.27	219.00	208.05	$32,666.38	304.95	$3,049,500
Summary for Provider = 050000605 – Eggen, Mark (37 detail records)										
$8,914.96	$8,469.21	37.00	35.15	$0.00	$0.00	0.00	0.00	$8,489.21	35.15	$351,500
Summary for "FAC" = MAPA (14839 detail records)										
$2,272,283.21	$2,213,494.42	10,603.00	10,072.85	$2,320,929.04	$2,264,278.69	30,126.00	28,619.70	$4,479,773.12	38,692.55	$386,925,500

Total Paid AA Cases	95% Total Paid AA Cases	Total Cases AA	95% Total Cases AA	Total Fraudulent Payments	Total Penalties
Summary for Provider = 050000100 – Tiu, Otello (1087 detail records)					
$83,729.11	$82,343.87	268.00	254.60	$82,343.87	$2,546,000
Summary for Provider = 050000101 – Stauffer, William (498 detail records)					
$6,409.11	$6,197.07	60.00	57.00	$6,197.07	$570,000
Summary for Provider = 050000102 – Peterson, John (1368 detail records)					
$52,893.92	$52,739.62	165.00	156.75	$52,739.62	$1,567,500
Summary for Provider = 050000103 – Giron, Luis (1212 detail records)					
$150,698.72	$147,644.73	481.00	456.95	$147,644.73	$4,569,500
Summary for Provider = 050000104 – Pereira, Xavier (972 detail records)					
$92,664.25	$90,846.24	324.00	307.80	$90,846.24	$3,078,000
Summary for Provider = 050000105 – Skoog, Richard (1243 detail records)					
$147,740.68	$144,938.21	415.00	394.25	$144,938.21	$3,942,500
Summary for Provider = 050000106 – Menzel, M (1026 detail records)					
$97,389.48	$95,945.35	290.00	275.50	$95,945.35	$2,755,000
Summary for Provider = 050000107 – Beverlin, Bryce (190 detail records)					
$175,765.81	$172,364.48	503.00	477.85	$172,364.48	$4,778,500
Summary for Provider = 050000108 – Dwarkeneth, Rajarso (1351 detail records)					
$156,385.12	$163,541.68	441.00	418.95	$153,541.68	$4,189,500
Summary for Provider = 050000109 – Shaw, Jeffrey (1171 detail records)					
$133,556.01	$131,081.90	461.00	437.95	$131,081.90	$4,379,500
Summary for Provider = 050000110 – Trennier, Robert (1129 detail records)					
$104,175.99	$102,335.49	312.00	296.40	$102,335.48	$2,984,000

Summary for Provider = 050000111 – Nissen, Mark (1608 detail records)					
$208,341.93	$204,406.30	585.00	665.25	$204,408.30	$5,652,500
Summary for Provider = 050000112 – Gudman, John (755 detail records)					
$49,269.35	$48,137.75	272.00	258.40	$48,137.75	$2,584,000
Summary for Provider = 050000113 – Munich, James (1128 detail records)					
$124,667.88	$122,547.68	401.00	380.95	$122,547.68	$3,809,500
Summary for Provider = 050000114 – Gayes, James (1485 detail records)					
$233,645.80	$228,154.49	747.00	709.85	$228,154.49	$7,096,500
Summary for Provider = 050000115 – Johnson, Richard (1090 detail records)					
$106,902.63	$107,058.12	352.00	334.40	$107,056.12	$3,344,000
Summary for Provider = 050000116 – Boening, Joan (988 detail records)					
$47,597.23	$46,568.23	240.00	228.00	$46,568.23	$2,280,000
Summary for Provider = 050000117 – Groves, Nancy (771 detail records)					
$18,632.45	$18,431.00	105.00	99.75	$18,431.00	$997,500
Summary for Provider = 050000118 – Wintermute, John (1275 detail records)					
$153,502.54	$150,312.62	408:00	387.60	$150,312.62	$3,496,000
Summary for Provider = 050000119 – Meisner, Judith (1062 detail records)					
$114,865.58	$113,050.00	368.00	349.60	$113,050.00	$3,496,000
Summary for Provider = 050000120 – Burke, Mitchell (1070 detail records)					
$177,773.10	$172,822.38	564.00	535.80	$172,822.38	$5,358,000
Summary for Provider = 050000387 – Plul, David (772 detail records)					
$108,306.46	$104,958.90	337.00	320.15	$104,958.05	$3,201,500
Summary for Provider = 050000388 – McKlveen, Robert (657 detail records)					
$103,806.16	$100,858.90	321.00	304.95	$100,856.90	$3,049,500

Summary for Provider = 050000457 – Lillehei, John (496 detail records)					
$71,005.65	$68,400.72	264.00	250.80	$88,400.72	$2,508,000
Summary for Provider = 050000467 – Blomberg, Richard (440 detail records)					
$88,675.82	$85,452.12	273.00	258.35	$85,462.12	$2,593,500
Summary for Provider = 050000478 – Engwell, Richard (248 detail records)					
$4,908.24	$4,887.92	43.00	40.85	$4,687.92	$408,500
Summary for Provider = 053810046 – Northwest Anesthesia, PA (6120 detail records)					
$572,431.28	$509,247.90	1,853.00	1,760.35	$589,247.98	$17,603,500
Summary for "FAC" = NIFA (32410 detail records)					
$5,459,396.96	$5,537,991.55	21,464.00	20,390.80	$5,537,991.51	$203,908,000

In The United States District Court
District of Minnesota

MANA, et al. vs. Unity Hospital, et al.

Deposition of Patrict Donohue-1/8/98

Donohue, Patrick V01 01/08/98

* * *

[27] A It's a bulletin that we issued to anesthesia providers in 1989.

Q I believe this was the earliest of the provider bulletins that you produced in connection with response to the subpoena, is that correct, earliest in time?

A It could be, yes.

Q Could you direct your attention to the second page of the exhibit, I guess it's page 3 of the document?

A (Examining document.)

Q Was the document responsive to the subpoena because of the material at the top of the page 3 beginning when an anesthesiologist and an anesthetist are both involved in a single procedure?

MR. STONE: Object to the form of the question.

A The document was produced because it was considered to be communications that we had with providers about anesthesia and that was one of the things called for in the subpoena.

Q Okay. Then could you identify Exhibit 1027 for me which also came from your files?

A It's a Medicare newsletter that was issued in August of 1991.

Q And I have a few questions about the bottom part of the second page, Anesthesiologist and CRNA – Single Service. [28] Could you take a moment to review that paragraph?

A (Examining document.)

Q Let me know when you're ready.

A All right.

Q Can you tell me what the background is to the publication of this paragraph, how this set of CPT codes came about?

A We had been advised by anesthetist providers as I recall that Blue Shield had come up with a list of procedure codes that they would assume medical necessity for both the anesthetist and the anesthesiologist's involvement in the request was that we would agree to the same list and we did and then published it.

Q So these are procedure codes on which Travelers considered and would reimburse for medically necessary CRNA services in addition to the anesthesiologist's service?

A That's correct.

Q And that would be on cases where there was no concurrent case? Correct?

A That's also correct.

Q All right. Did Travelers ever issue any instructions to providers as to – let me start over. Am I correct that there are two modifiers under which CRNAs could bill, one for medically directed services and one for [29] nonmedically directed services?

A That's correct.

Q Did Travelers ever issue any instruction as to which modifier CRNAs were to use in billing for these medical necessity cases?

A No.

Q Was it your understanding that the services would be billed using the medically directed modifier?

A That's correct.

Q And am I also correct that Travelers would reimburse at two different rates for CRNA services, a medically directed rate and a nonmedically directed rate?

A That's correct.

Q And what reimbursement rate were CRNA services on medical necessity cases reimbursed?

A I don't recall what it was at that time.

Q Has it changed over time?

A Yes.

Q So at one time it was the nonmedically directed and at one time it was the medically directed rate?

A I'm sorry. I misunderstood the original question I think.

Q Okay. Let's go back. Medicare reimburses for CRNA services at one of two rates, medically directed or nonmedically directed? Is that correct?

* * *

[145] A. Yes.

Q What was that?

A An 11 county area that encompassed the south-eastern corner of the state, Twin City and Rochester areas.

Q When did your territory expand?

A March 1st of 1996.

Q It went from the 11 county area to the entire state?

A Correct.

Q You in effect took over the carrier duties that Blue Cross/Blue Shield had been performing?

A For the Part B side of Medicare, yes.

Q How many anesthesia providers were there in the 11 county territory that you had?

A I don't know.

Q Do you have any estimate?

A I really have no idea.

Q Do you have any idea how many anesthesia providers are in the State of Minnesota?

A No.

Q Despite the appearance of this deposition, your job encompasses more than dealing with anesthesia billing? Right?

A Most of the time, yes.

Q Can you rank for us the relative complexity of Medicare billing regulations for anesthesia compared to Medicare [146] regulations for billing in other medical specialties?

MR. STONE: Object to the form of the question.

A Anesthesia would be at the top.

Q Why is that?

A It's more complex than the other areas.

Q And why is it more complex than the other areas?

A Because the whole pricing and allowable charge concepts are different than for other medical services.

Q Can you give us a general summary of why they're different? What are the other medical services' charge based on?

A For example, another physician service, say a visit or a physical examination is identified to us by a procedure code and we have an allowance in our system for that procedure code. It's as simple as that. With regard to anesthesia, there is a basic value for every anesthesia procedure but with regard to the specific procedure there's a time element that is also reflected in the allowance and the charge and then the distinction between a personally performed service and a medically directed service both for the anesthesiologist and for the anesthetist.

Q Do any of the other medical services have concepts such as personal performance versus medically directed?

* * *

[SEAL]

FOR IMMEDIATE RELEASE

CIV

THURSDAY, FEBRUARY 24, 2000

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JUSTICE DEPARTMENT RECOVERS OVER $3 BILLION IN WHISTLEBLOWERS FALSE CLAIMS ACT AWARDS AND SETTLEMENTS

WASHINGTON, D.C. – More than $3 billion has been recovered in civil fraud cases brought under the whistleblower provisions of the False Claims Act, since the law was amended in 1986, the Justice Department announced today. Almost half of the recoveries have come in the last two and a half years. "It took us 12 years – to the end of fiscal year 1998 – to recover $2 billion in civil fraud cases brought under the whistleblower provisions," said Acting Assistant Attorney General David W. Ogden for the Civil Division. "We have reached the $3 billion mark just 16 months later." Ogden stressed that besides providing monetary recovery, the whistleblower suits have also had a deterrent effect among recipients of federal funds. The False Claims statute allows private persons, known as "relators," to file suit on behalf of the United States alleging that false or fraudulent claims have been submitted to the government. Persons who file *qui tam* suits may recover from 15 to 25 percent of the settlement or judgment if the federal government intervenes in the case, or

up to 30 percent if they pursue it on their own. More than 3000 such suits have been filed since 1986. The number of *qui tam* suits filed has risen from 33 per year in the year after 1986 to 483 in the last fiscal year. The whistleblower provisions have yielded recoveries of more than $3.5 billion to date: $3.3 billion in cases that the Department of Justice pursued and $211 million in cases litigated by whistleblowers after the Department of Justice declined to pursue the case. The Department of Justice has paid whistleblowers more than $550 million as their statutory shares, with additional awards pending. "The False Claims Act's *qui tam* provisions have provided a remarkable return for the taxpayers of this country," said Ogden. "The Department of Justice's recovery of more than $3.3 billion through whistleblower suits demonstrates that the public-private partnership encouraged by the statute works and is an effective tool in our continuing fight against the fraudulent use of public funds." Among the most recent recoveries are:

- National Medical Care, now also known as Fresenius Medical Care, North America, the largest provider of dialysis services in the United States, agreed to pay $375 million to resolve *qui tam* allegations that the company submitted false claims for laboratory tests and conspired to pay illegal kickbacks. This is the largest civil recovery in a health care fraud case.

- Beverly Enterprises Inc., the nation's largest operator of nursing homes, agreed to pay $170 million to settle allegations that it defrauded Medicare by fabricating records to make it appear that nurses were devoting

much more time to Medicare patients than they actually were.

- Olsten Corporation paid $40.9 million to settle allegations that Olsten and Columbia/HCA had disguised unallowable acquisition costs as allowable management fees when Columbia/HCA acquired home health agencies in several states. Olsten and its subsidiaries had provided management and staffing services for the home health agencies.

While almost half of the *qui tam* filings, and more than half of the *qui tam* recoveries, involve health care fraud, whistleblower suits have alleged fraud against a wide range of federal government agencies. For example:

- Chevron Corporation agreed to pay the U.S. $86.2 million to resolve whistleblower claims under the False Claims Act that the corporation and affiliated companies underpaid royalties due for oil produced on federal and Indian leases since 1988.

- Mobil Oil Corporation agreed to pay the U.S. $45 million, and Oxy-USA, Inc. paid $7.3 million, to resolve similar claims of underpayment of royalties.

Ogden praised the work of Senator Charles Grassley of Iowa and Representative Howard L. Berman of California, who sponsored the 1986 amendments that made it easier for such cases to be filed. He also stressed that the recoveries could not have been achieved without the outstanding and tireless efforts of the attorneys in the Civil Division and the United States Attorneys' offices

throughout the country working in cooperation with agency investigators.

###

00-079

U.S. Department of Justice
Office of the Deputy Attorney General

The Deputy Attorney General *Washington, DC 20530*

June 3, 1998

MEMORANDUM FOR: All United States Attorneys
All First Assistant United States Attorneys
All Civil Health Care Fraud Coordinators in the Offices of United States Attorneys
All Trial Attorneys in the Civil Division Commercial Litigation Section

FROM: Eric H. Holder, Jr.
Deputy Attorney General

SUBJECT: Guidance on the Use of the False Claims Act in Civil Health Care Matters

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One of the Department's most important tools in protecting the integrity of Medicare and other taxpayer-funded health care programs is the civil False Claims Act. While the broad reach and substantial damages and civil penalties under the Act make it one of the Department's most powerful tools, Departmental attorneys are obligated to use their authority under the Act in a fair and responsible manner. This is particularly important in the context of national initiatives, which can have a broad impact on health care providers across the country.

This guidance is being issued to emphasize the importance of pursuing civil False Claims Act cases against health care providers in a fair and even-handed manner, and to implement new procedures with respect to the development and implementation of national initiatives.

1. National Initiatives.

Generally, national initiatives deal with a common wrongful action accomplished in a like manner by multiple, similarly situated health care providers. National initiatives must be handled in a manner (i) that promotes consistent adherence to the Department's policies on enforcement of the False Claims Act, as well as a consistent approach to overarching legal and factual issues, (ii) while avoiding any rigid approach that fails to recognize the particular facts and circumstances of an individual case.

To achieve these objectives, the Department has instituted the following procedures:

(A) Legal and Factual Predicates.

Before alleging violations of the False Claims Act, whether in connection with a national initiative or otherwise, Department attorneys must evaluate whether the provider: (i) submitted false claims to the government, and (ii) submitted false claims (or any false statements made to get the false claims paid) with "knowledge" of their falsity, as defined in the Act. These are separate inquiries. Department attorneys shall not allege a violation of the False Claims Act unless both of these inquiries lead to the conclusion that there is a sufficient legal and factual

predicate for proceeding. The following issues, among other issues, shall be considered in these determinations:

(i) Do False Claims Exist?

a. *Examine Relevant Statutory and Regulatory Provisions and Interpretive Guidance.* Department attorneys shall examine relevant statutory and regulatory provisions, as well as any applicable guidance from the program agency or its agents, to determine whether the claims are false. In certain circumstances, such as when a rule is technical or complex, Department attorneys should communicate with knowledgeable personnel within the program agency (*e.g.*, the Health Care Financing Administration, TRICARE, Office of Personnel Management) concerning the meaning of the provision.

b. *Verify the Data and Other Evidence.* Department attorneys shall take appropriate steps to verify the accuracy of data upon which they are relying, either independently, or with the assistance of the fiscal intermediaries and carriers, the Department of Health and Human Services – Office of Inspector General, the Federal Bureau of Investigation, or another investigative agency.

c. *Conduct the Necessary Investigative Steps.* Department attorneys should conduct such investigative steps as are necessary under the circumstances, including where appropriate, the subpoenaing of documents and the interviewing of witnesses.

(ii) Did the Provider Knowingly Submit the False Claims?

In the event the claims are false, Department attorneys must next evaluate whether the health care provider "knowingly" submitted the false claims or "knowingly" made false statements to get the false claims paid. As set forth above, and before making this determination, Department attorneys should conduct such investigative steps as necessary under the circumstances, including where appropriate the subpoenaing of documents and the interviewing of witnesses. Under the False Claims Act, false claims and false statements are submitted "knowingly" if the provider had actual knowledge of their falsity, or acted with deliberate ignorance or reckless disregard as to their truth or falsity. While relevant factors will vary from case to case and the list below is not intended to be exhaustive, factors that must be considered are:

a. *Notice to the Provider*. Was the provider on actual or constructive notice, as appropriate, of the rule or policy upon which a potential case would be based?

b. The Clarity of the Rule or Policy. Under the circumstances, is it reasonable to conclude that the provider understood the rule or policy?

c. *The Pervasiveness and Magnitude of the False Claims*. Is the pervasiveness or magnitude of the false claims sufficient to support an inference that they resulted from deliberate ignorance or intentional or reckless conduct rather than mere mistakes?

d. *Compliance Plans and Other Steps to Comply with Billing Rules*. Does the health care

provider have a compliance plan in place? Is the provider adhering to the compliance plan? What relationship exists between the compliance plan and the conduct at issue? What other steps, if any, has the provider taken to comply with billing rules in general, or the billing rule at issue in particular?

e. *Past Remedial Efforts*. Has the provider previously on its own identified the wrongful conduct currently under examination and taken steps to remedy the problem? Did the provider report the wrongful conduct to a government agency?

f. *Guidance by the Program Agency or its Agents*. Did the provider directly contact either the program agency (*e.g.*, the Health Care Financing Administration) or its agents regarding the billing rule at issue? If so, was the provider forthcoming and accurate and did the provider disclose all material facts regarding the billing issue for which the provider sought guidance? Did the program agency or its agents, with disclosure of all relevant, material facts, provide clear guidance? Did the provider reasonably rely on such guidance in submitting the false claims?

g. *Have There Been Prior Audits or other Notice to the Provider of the Same or Similar Billing Practices*?

h. *Any Other Information That Bears on the Provider's State of Mind in Submitting the False Claims*.

(B) Oversight by National Initiative Working Groups.

For all current and future national initiatives, the Attorney General's Advisory Committee (AGAC) and the Civil Division shall establish a working group to coordinate the development and implementation of each initiative.

Working groups will be comprised of Assistant United States Attorneys and Civil Division attorneys with particular expertise in health care fraud. In accordance with the health care guidelines promulgated in January 1997, in appropriate instances each working group may also need to coordinate and plan the initiative with the Department's Criminal Division.

Each working group will (i) examine the initiative to ensure that a factual and legal predicate is present for the initiative prior to its implementation, (ii) prepare initiative-specific guidance and sample documents (such as legal analyses, summaries of audit data, contact letters, tolling agreements, compliance and settlement agreement language) for use in the initiative, and (iii) prepare a general investigative plan, setting forth suggested investigative steps that each office should undertake prior to proceeding. Working groups shall be responsible for coordination with law enforcement agencies, the Health Care Financing Administration, and other appropriate entities.

While the working groups shall be responsible for coordinating the overall development and implementation of national initiatives, each matter against a specific provider must be evaluated on a case-by-case basis.

(C) Use of Contact Letters in National Initiatives.

As outlined above, Department attorneys participating in national initiatives shall, in general, make initial contacts with health care providers, to resolve a case, through the use of "contact" letters. The purpose of a contact letter is to notify a provider of their potential exposure under the False Claims Act and to offer the provider an opportunity to discuss the matter *before* a specific demand for payment is made. In limited circumstances, where the specific facts of a situation warrant a different approach, Department attorneys may make an initial contact through other legitimate means.

The use of contact letters to make initial contact with health care providers is in furtherance of Executive Order 12988, which obligates Department attorneys to make a reasonable effort to notify the opposing party about the nature of the allegations, and attempt to resolve the dispute without litigation if at all possible. The type of contact employed will depend on the nature of the allegations and the stage of the investigation. Regardless of the form of initial contact, Department attorneys must ensure that health care providers are afforded: (i) an adequate opportunity to discuss the matter before a demand for settlement is made, and (ii) an adequate time to respond. In addition, Department attorneys shall grant all reasonable requests for extensions of time to the extent that they do not jeopardize the government's claims. The use of statutory tolling agreements are strongly encouraged to allow providers time to respond without jeopardizing the government's claims.

2. Alternative Remedies.

After reviewing the legal and factual circumstances of a particular matter, Department attorneys shall consider other available remedies – including administrative remedies such as recoupment of overpayments, program exclusions, and civil monetary penalties – to determine what remedy, or combination of remedies, would be the most suitable under the circumstances. Should the recoupment of an overpayment be the most appropriate remedy, Department attorneys shall consider referring the matter to the appropriate carrier/fiscal intermediary for appropriate action.

3. Ability to Pay Issues.

Attorneys shall consider any financial constraints identified by a provider in determining a fair, reasonable and feasible settlement between the parties. Hospitals and other health care providers citing an inability to pay a specific settlement amount should be asked to present documentation in support of their stated financial condition.

4. Rural and Community Health Care Provider Concerns – Impact on Availability of Medical Services.

When dealing with rural and community hospitals and other health care providers, Department attorneys shall consider the impact an action may have on the community being served. In determining an appropriate resolution, or deciding whether to bring an action, care must be taken to consider the community's interest in

access to adequate health care along with any other relevant concerns.

5. Hospitals and Other Health Care Providers Not Represented by Counsel.

Department attorneys shall pay special attention to contacts with hospitals and other providers that choose (due to financial constraints or otherwise) to resolve claims without legal representation. Department attorneys faced with this circumstance must carefully assess every action taken to avoid even an appearance of coercion or overreaching because of the absence of opposing counsel.

6. Minimizing Burdens Imposed on Providers During Investigations.

Department attorneys also should be mindful of the ways in which our investigations and audits can disrupt and burden the day-to-day operations of providers in both a financial and practical sense. In developing and implementing an investigative plan, we should do what we can do to minimize these adverse effects, while still meeting our obligation to diligently investigate allegations of potential fraud. For example, while recognizing that certain circumstances might warrant different approaches, Department attorneys should consider a provider's request to accept the results of an audit of a sample of claims in lieu of a complete audit.

7. Provider Assistance with the Investigation.

In determining an appropriate settlement amount, Department attorneys should consider the extent to which a health care provider has cooperated with the audit or investigation of the relevant matter.

8. Individualized Review.

The proper determination as to the use and application of the False Claims Act or other appropriate remedy requires an individualized review of each case, ensuring that each of the above factors are given full consideration

9. Review of Guidance.

In order to assure the fair and appropriate application of the False Claims Act, this guidance will be subject to review in six months.

10. Additional Information.

Questions regarding use of the False Claims Act should be referred to the Health Care Fraud Coordinator in your district, or to Robert Liles, Health Care Fraud Coordinator for the Executive Office for United States Attorneys (tel. no. 202-616-5136), or Shelley R. Slade, Health Care Fraud Coordinator for the Civil Division (tel. no. 202-307-0264).

N 0208

[SEAL]

STATE OF MINNESOTA

Department of State

In All To Whom These Presents Shall Come, Greeting:

Whereas, Articles of Incorporation, duly signed and acknowledged under oath, have been recorded in the office of the Secretary of State, on the **-7th-** day of **April**, A. D. 19**75** for the incorporation of **Minnesota Association of Nurse Anesthetists** under and in accordance with the provisions of the Minnesota Nonprofit Corporation Act, Minnesota Statutes, Chapter 317,

Now, Therefore, I, Joan Anderson Growe, Secretary of State of the State of Minnesota, by virtue of the powers and duties vested in me by law, do hereby certify that the said **Minnesota Association of Nurse Anesthetists** is a legally organized Corporation under the laws of this State.

Witness my official signature hereunto subscribed and the Great Seal of the State of Minnesota hereunto affixed this **-seventh-** day of **-April-** in the year of our Lord one thousand nine hundred and **seventy-five**

/s/ Joan Anderson Growe
Secretary of State.

ARTICLES OF INCORPORATION
OF
MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS

We, the undersigned, being citizens of the United States, and all for the purpose of forming a charitable and benevolent corporation pursuant to the Minnesota Non-profit Corporation Act, Chapter 317 of the Minnesota Statutes, do hereby certify:

ARTICLE I

Name

The name of this corporation shall be MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS.

ARTICLE II

Purpose

It shall be the objects of this Association to promote the best interests of its members, cooperate with the American Association of Nurse Anesthetists, facilitate cooperation between nurse anesthetists and the medical profession, hospitals and other agencies interested in anesthesia, act as collective bargaining agent for its members, and in general to advance the science and art of anesthesia.

ARTICLE III

Authority and Restrictions

This corporation shall have the authority, in addition to but not by way of limitation of any authority conferred upon it by law:

A. To acquire by way of gift, devise, bequest, purchase or otherwise, or to lease or construct or cause to be constructed, facilities for maintaining and carrying out the work and activities of this corporation, either alone or in conjunction with others and on premises owned or leased by this corporation or on premises owned or leased by others; to acquire by gift, devise, purchase, or otherwise, and to own, hold, improve, lease, mortgage, pledge, sell, assign, transfer, convey, manage or otherwise deal in and with, the exercise of all rights of ownership in or in respect of every kind of real estate, improved or unimproved, and to procure buildings, structures or other improvements on any such real estate as may be necessary or convenient for carrying out any lawful purpose of this corporation.

B. To acquire, by way of gift, devise, bequest, purchase, or otherwise, and to hold, sell, assign, transfer, mortgage, pledge, or otherwise dispose of personal property of every kind, including shares, stocks, bonds, debentures, securities, and other obligations or evidence of indebtedness of any other corporation or foundation, either profit or nonprofit, public or private, domestic or foreign, as investments or otherwise, where it is necessary or proper for, or in connection

with any lawful purpose of this corporation and, while the owner thereof, to exercise all rights, powers and privileges of ownership, including the power to vote thereon.

C. To take, receive, and hold any real or personal property that is given, conveyed, bequeathed or devised to, or otherwise vested in the corporation, including the income there from, or both, and any income from or interest on any other money, property or fund that is given or bequeathed to the corporation, in trust for any purpose, subject to any use or condition, or upon any special or executory limitation that is consistent with the purposes of this corporation as set forth in these Articles.

D. To prepare for publication, publish or cause to be published, produce, manufacture, distribute, disseminate, exhibit, show or furnish for exhibition or showing, sponsor, or otherwise promote or develop, directly or indirectly, such books, pictures, magazines, papers, pamphlets, and other printed matter and such lectures, performances, exhibitions, motion pictures, radio programs, television programs, and the like as may be necessary, suitable, or convenient for carrying out the lawful purpose of this corporation.

E. To borrow money and incur indebtedness for any lawful purpose of this corporation from time to time without limit as to amount, and in connection therewith, to draw, make, accept, endorse, execute and issue notes, drafts, bills of exchange, bonds, debentures, and other negotiable or non-negotiable

instruments or evidences of indebtedness of any nature, and to secure payment thereof, and any interest thereon, by mortgage, pledge, deed of trust, assignment, or otherwise on or of any part or all of the assets of this corporation, including assets thereafter to be acquired.

F. To do all other acts and things and carry on and conduct all other activities necessary, suitable, convenient, useful, or expedient in connection with, or incidental to the accomplishment of, any of the purposes set forth in Article II of these Articles to the full extent permitted by the laws of the State of Minnesota.

G. To pursue its purposes and conduct and carry on any and all lawful business or activities in connection therewith or incidental thereto, or any part thereof, in the State of Minnesota, in any other state, territory, or possession of the United States, in the District of Columbia, and in any foreign country or countries, except that if any donor or contributor shall so specify, his or its gift or contribution shall be used by the corporation only within the United States or its possessions, or within any other territorial limits specified by that donor or contributor.

Notwithstanding any other provision of these Articles of Incorporation the corporation shall at all times be subject to the following restrictions:

A. The corporation shall neither have nor exercise any powers nor shall it engage directly or indirectly in any activity, that would invalidate its status as a corporation which is

exempt from Federal income taxation as an organization described in section 501(c)(6) of the Internal Revenue Code of 1954.

B. No substantial part of the activities of this corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation; nor shall it be in any manner or to any extent participate in, or intervene in any political campaign on behalf of any candidate for office; nor shall the corporation engage in any activities that are unlawful under applicable Federal, State, or local laws.

C. This corporation shall not operate for the primary purpose of carrying on a trade or business or any other activity for profit.

ARTICLE IV

No Pecuniary Gain to Members

No part of the net earnings of the corporation shall inure to the benefit of or be distributable to its members, directors, officers, or other private persons, except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of the purposes set forth in Article II hereof.

ARTICLE V

No Personal Liability

The members, officers and directors of this corporation shall have no personal liability for corporate obligations.

ARTICLE VI

Registered Office

The location and Post Office address of the registered office of this corporation in the State of Minnesota shall be 319 – 15th Avenue S.E., c/o State Organization Services, Minneapolis, Minnesota, 55414.

ARTICLE VII

Directors

The corporation shall be operated by a Board of Directors the number of which is to be no more than twelve (12) and no less than three (3). The directors of the corporation are to be elected in accordance with the By-Laws. Such directors shall hold their offices for one year, or such other period as the By-Laws shall determine, or until their successors are duly elected and qualified. The names and places of residence of the persons to be the corporation's first Board of Directors are as follows:

Harry Janky
1814 N. W. 16th Street
Faribault, MN 55021

Alyce Heim
5345 Bryant Avenue South
Minneapolis, MN 55419

Sandra Kilde
11784 Madison Street N.E.
Blaine, MN 55434

Joy Majors
11784 Madison Street N.E.
Blaine, MN 55434

Dolores Ginsberg
226 Howard Gnesen Road
Duluth, MN 55811

Robert Steffenson
Route 1, Box 850A
Alexandria, MN 56308

Betty K. Nordine
1418 – 15th Avenue N.E.
Rochester, MN 55901

Beatrice Williams
5333 – 48th Avenue South
Minneapolis, MN 55417

John Benner
1807 N. W. Second Avenue
Austin, MN 55912

ARTICLE VIII

Duration

The duration of this corporation shall be perpetual.

ARTICLE IX

Dissolution

Upon the dissolution of the corporation, the Board of Directors shall, after paying or making provision for the payment of all of the liabilities of the corporation, distribute all assets of the corporation exclusively for the purposes of the corporation in such manner, or to such organization or organizations organized and operated exclusively for charitable, educational, religious, or scientific purposes as shall at the time qualify as an organization or organizations described in section 501 (c)(3) of the Internal Revenue Code of 1954, as the Board of Directors shall determine.

ARTICLE X

No Capital Stock

This corporation shall have no capital stock.

ARTICLE XI

Incorporators

The names and addresses of each incorporator of this corporation is:

Harry Janky
1814 N.W. 16th Street
Faribault, MN 55021

Sandra Kilde
11784 Madison Street N.E.
Blaine, MN 55434

Alyce Heim
5345 Bryant Avenue South
Minneapolis, MN 55419

ARTICLE XII

Construction

All references herein to provisions of the Internal Revenue Code of 1954 shall be deemed to include statutes which have succeeded such provisions as they are duly enacted by congress.

ARTICLE XIII

Amendment

These Articles may be amended in any manner now or hereafter prescribed by law, except that two-thirds (⅔) vote of the entire Board of Directors shall be required for the adoption of any amendment by the Board of Directors, either pursuant to authorization of the members or otherwise.

We, the incorporators, sign our names this 2nd day of April 1975.

In the Presence of:

/s/ Harry Janky
Harry Janky

/s/ Diane M. Laija

/s/ Sandra Kilde
Sandra Kilde

/s/ Cahler

/s/ Alyce Heim
Alice Heim

STATE OF MINNESOTA)
) SS
COUNTY OF HENNEPIN)

On this 2nd day of April, 1975, before me, a Notary Public within and for said County, personally appeared Harry Janky, Sandra Kilde, and Alyce Heim, to me known to be the persons described in and who executed for foregoing instrument and acknowledged that they executed the same as their own free act and deed.

/s/ Philip J. Haleen
Notary Public

[SEAL]
PHILIP J. HALEEN
NOTARY PUBLIC – MINNESOTA
HENNEPIN COUNTY
My Commission Expires Jan. 5, 1982

STATE OF MINNESOTA
DEPARTMENT OF STATE

I hereby certify that the within instrument was filed for record in this office on the 7 day of APRIL A.D. 1975,

at 8 o'clock A.M., and was duly recorded in Book M-43 of incorporations, on page 195

/s/ Joan Anderson Growe
Secretary of State

CERTIFICATE OF AMENDMENT OF
ARTICLES OF INCORPORATION

of

MINNESOTA ASSOCIATION OF
NURSE ANESTHETISTS

We, the undersigned ALYCE A. HEIM and THOMAS G. HEALEY, respectively the president and secretary of MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS, a non-profit corporation to hereby certify that at a (regular meeting of the members of said corporation) XX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, duly called and held in the City of MINNEAPOLIS on JANUARY 18, 1978 at EIGHT o'clock P.M., at which meeting a majority of the members were represented in person or by proxy, resolutions, as hereinafter set forth, were adopted by a majority vote of said members:

"RESOLVED that Articles VI, of the Articles of Incorporation of THE MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS be, and the same hereby (is)

(~~are~~) amended to read as follows:

ARTICLE VI

The location and Post Office address of the registered office of this corporation in the State of

Minnesota shall be 2353 Rice Street, North, c/o Carter/Locey and Associates, St. Paul, Minnesota 55113.

RESOLVED further that the president and secretary of this corporation be and they hereby are, authorized and directed to make, execute and acknowledge a certificate under the corporate seal of this corporation embracing the foregoing resolutions, and to cause such certificate to be filed and recorded in the manner required by law.

And we do further certify that the said resolutions, and said articles of incorporation so amended, were at a meeting of the board of directors, held on the 18th day of January, 1978 at which a majority of all the members of said board were present and voted, duly adopted, ratified.

IN WITNESS WHEREOF, we, the undersigned, have subscribed our names and caused corporate seal of said corporation to be hereto affixed this 5th day of February, 1978.

In presence of:

/s/ Alyce A. Heim
/s/ Thomas G. Healey

ALYCE A. HEIM
President
THOMAS G. HEALEY
Secretary

(Corporate Seal) NO CORPORATE SEAL

STATE OF MINNESOTA,

ss.

COUNTY OF HENNEPIN

ALCYE A. HEIM and THOMAS G. HEALEY being first duly sworn, on oath depose and say: that they are respectively the ___president and ___secretary of THE MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS, the corporation named in the foregoing certificate; that said certificate contains a true statement of the action of the members and board of directors of said corporation, duly held as aforesaid: (XXXXXXXXXXXXXXXXXXXXXXXXXX) (THAT THIS CORPORATION HAS NO CORPORATE SEAL) that said certificate is executed on behalf of said corporation, by its express authority; and they further acknowledge the same to be their free act and deed and the free act and deed of said corporation.

/s/ Alyce Heim President
/s/ Thomas G. Healey Secretary

Subscribed and sworn to before me this 23rd day of October 1977.

/s/ Charles F. Beecroft Notary Public
Hennepin County, Minnesota
My commission expires 12/17/1982

(Notarial Seal)

[SEAL]
CHARLES F. BEECROFT
NOTARY PUBLIC – MINNESOTA
HENNEPIN COUNTY
My Commission Expires Dec. 17, 1982

———

STATE OF MINNESOTA
DEPARTMENT OF STATE

I hereby certify that the within instrument was filed for record in this office on the 17 day of MARCH A.D. 1978, at 8 o'clock A.M., and was duly recorded in Book A-48 of incorporations, on page 946

/s/ Joan Anderson Growe
Secretary of State

[SEAL]

State of Minnesota
Office of the Secretary of State

CERTIFICATE OF CHANGE OF
REGISTERED OFFICE
by

Name of Corporation

Minnesota Association of Nurse Anesthetists

Pursuant to Minnesota Statues Section 301.33, 302A.123, or 317.19, the undersigned hereby certifies that the Board of Directors of the above named Minnesota corporation has resolved to change the corporation's registered office:

FROM
Address (No. & Street)
XXXXXXXXXX 2353 N. Rice St.
City XXXXXXXXXX Roseville
County XXXXXXXXXX Ramsey MN
Zip XXXXXXXXXX 55113

TO
Address (No. & Street)
University Technology Center, Suite 329 B
1313 – 5th Street S.E.
City Minneapolis County Hennepin MN
Zip 55414

The effective date of the change will be the 3rd day of November, 1988 or the day of filing of this certificate with the Secretary of State, whichever is later.

Name of Officer or Other Authorized Agent of Corporation

Lodemia R. Hartley
Signature
/s/ Lodemia R. Hartley
Title or Office President
Date November 14, 1988

REQUIRED FOR 302a CORPORATIONS ONLY

STATE OF MINNESOTA
County of Hennepin ss.

The foregoing instrument was acknowledged before me this 14th day of November, 1988.

/s/ Lois J. Oppen
Notary Public

(Notarial Stamp)
[SEAL]
Lois J. Oppen
NOTARY PUBLIC MINNESOTA
DAKOTA COUNTY
MY COMMISSION EXPIRES JUN 16, 1991

[SEAL]

STATE OF MINNESOTA
SECRETARY OF STATE
NOTICE OF CHANGE OF REGISTERED OFFICE/
REGISTERED AGENT

1. Corporate Name:

Minnesota Assn of Nurse Anesthetists

2. Registered Office Address (No. & Street): List a complete street address or rural route and rural route box number. A post office box is not acceptable.

7200 France Av. So. #230 Edina
Street City

MN 55435
State Zip Code

3. Registered Agent (Registered agents are required for foreign corporations but optional for Minnesota corporations):

NONE

If you do not wish to designate an agent, you must list "NONE" in this box. DO NOT LIST THE CORPORATE NAME.

In compliance with Minnesota Statutes, Section 302A.123, 303.10, 308A.025, 317A.123 or 322B.135 I certify that the above listed company has resolved to change the company's registered office and/or agent as listed above.

I certify that I am authorized to execute this certificate and I further certify that I understand that by signing this certificate I am subject to the penalties of perjury as set

forth in *Minnesota Statutes Section 609.48* as if I had signed this certificate under oath.

/s/ Steve Halls Treasurer
Signature of Authorized Person
Name and Telephone Number of a Contact Persons:

Steven C. Hendrickson (612) 571-6616
please print legibly

Filing Fee:
Minnesota Corporations, Cooperatives and Limited Liability Companies: $35.00.

Non-Minnesota Corporations: $50.00.

Make checks payable to

Secretary of State
Return to:

Minnesota Secretary of State
180 State Office Bldg.
100 Constitution Ave.
St. Paul, MN 55155-1299
(612) 296-2803

Office Use One

(Filed
Jun. 1, 1994)

[SEAL]

MINNESOTA SECRETARY OF STATE

AMENDMENT OF ARTICLES OF INCORPORATION

READ INSTRUCTIONS LISTED BELOW, BEFORE COMPLETING THIS FORM.

1. Type or print in black ink.
2. There is a $35.00 fee payable to the Secretary of State for filing this "Amendment of Articles of Incorporation".
3. Return Completed Amendment Form and Fee to the address listed on the bottom of the form.

CORPORATE NAME: (List the name of the company prior to any desired name change)

MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS EDUCATION & RESEARCH FOUNDATION

This amendment is effective on the day it is filed with the Secretary of State, unless you indicate another date, no later than 30 days after filing with the Secretary of State.

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format(mm/dd/yyyy)

The following amendment(s) to articles regulating the above corporation were adopted: (insert full text of newly amended article(s) indicating which article(s) is (are) being amended or added.) If the full text of the amendment will not fit in the space provided, attach additional numbered pages. (Total number of pages including this form I.)

ARTICLE I

The name of this corporation shall be Norm Paradise Nurse Anesthesia Education and Research Foundation.

This amendment has been approved pursuant to *Minnesota Statutes chapter 302A or 317A.* I certify that I am authorized to execute this amendment and I further certify that I understand that by signing this amendment, I am subject to the penalties of perjury as set forth in section 609.48 as if I had signed this amendment under oath.

/s/ Leslie A. Johnson RN, CRNA, MS
(Signature of Authorized Person)

Name and telephone number of contact person:
LESLIE A. JOHNSON (715) 262-0043
Please print legibly

All of the information on this form is public and required in order to process this filing. Failure to provide the requested information will prevent the Office from approving or further processing this filing.

If you have any questions please contact the Secretary of State's office at (651) 296-2803.

(Filed Dec. 11, 2001)

RETURN TO:
Secretary of State
180 State Office Bldg., 100 Constitution Ave.
St. Paul, MN 55155-1299, (651) 296-2803

STATE OF MINNESOTA
DEPARTMENT OF STATE

I hereby certify that this is a true and complete copy of the document as filed for record in this office.

DATED 1/25/2002
/s/ Mary Kiffmeyer
Secretary of State

[SEAL]
By Evan Hiltman

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

UNITED STATES OF AMERICA, *ex rel.* MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS, Plaintiff, vs. ALLINA HEALTH SYSTEM CORP., et al. Defendants.	**Civil No. 4-96-734 ADM/JGL** **AFFIDAVIT OF MARY VICTORIA YARNS**

State of Minnesota)
) ss.
County of Hennepin)

Mary Victoria Yarns, being sworn, states as follows:

1. I am the Manager of Regulatory Billing for the Allina Health System Consolidated Business Office ("CBO").

2. "Medical necessity" cases are those procedures that the Medicare carrier (formerly known as Travelers and currently known as United Health Care), has designated as procedures for which the carrier will pay for two anesthesia providers, even if the anesthesiologist on the case bills the case as "one-on-one" or personally performed. The carrier has made the decision that these procedures, designated by nine CPT Codes, are sufficiently difficult or

complicated so as to require the services of two anesthesia providers. The relevant page from the March 1997 policy manual listing the nine CPT Codes is attached as an exhibit to this affidavit.

3. To the best of my knowledge and based on my personal experience, when Allina employed CRNAs at Unity and Mercy Hospitals, the CBO billed for CRNA services on Medicare medical necessity cases at Unity and Mercy under the "medically directed" modifier. Abbott Northwestern Hospital became part of Allina's predecessor, HealthSpan, in 1993. From 1993 until July, 1994, Abbott's CRNA charges were billed on a system separate from Unity and Mercy, but the practice would still be to bill Medicare medical necessity cases as medically directed. After July, 1994, Abbott's CRNA charges were billed on the same system as Unity and Mercy and, to the best of my knowledge and based on my personal experience, such charges were billed as medically directed in Medicare medical necessity cases.

/s/ Mary Victoria Yarns
Mary Victoria Yarns

[SEAL] PAMELA J. THORSEN
NOTARY PUBLIC MINNESOTA
My Commission Expires
Jan. 31, 2000

Subscribed and sworn to before me
this 31st day of July, 1998.

/s/ Pamela J. Thorsen
Notary Public

No. 123 SEPTEMBER 1993

MEDICARE NEWS

An Information Service From The Travelers Companies

The Travelers [LOGO]

Part B Medicare Office • 8120 Penn Ave. So. • Bloomington, MN 55431 • Mike Esterley, District Mgr. • Phone (612) 884-3030

REVISED TRANSITION SCHEDULE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS)

The Health Care Financing Administration has announced that the transition of those DMEPOS claims originally scheduled for 10/1/93 has been postponed until 11/1/93. This affects residents of the State of Minnesota. We will continue to process DMEPOS claims received in our office prior to 11/1/03.

If you have specific questions regarding the postponement, please contact the Durable Medical Equipment Regional Contractor at 1-800-346-2233.

* * *

ANESTHESIA PAYMENT POLICIES

The Health Care Financing Administration Bureau of Policy and Development has issued the following payment policies. They were asked to clarify the policies that apply when: (1) the starting point of one anesthesia procedure and the ending point of a second anesthesia procedure as the same for medically directed anesthesia procedures; and (2) an anesthesiologist and a certified registered nurse

anesthetist (CRNA) are both involved in a single anesthesia procedure. This is their response:

We would recognize two concurrent procedures if there are two anesthesia procedures, each of which is being performed by a CRNA, and the ending point of procedure A is the same as the starting point of procedure B. If, for example, an anesthesiologist is involved with two procedures, and one anesthesia procedure ends at 10:00 while the second procedure begins at 10:00, then we will consider this case to be two procedures medically directed by the anesthesiologist. Thus, these procedures would be reported with the QJ modifier and not the AA modifier used for personally performed procedures. Consequently, each of these procedures would be subject to the 10 percent base unit reduction and would be permitted half the time units of a personally performed procedure.

Under the regulations, an anesthesia procedure is considered personally performed by the physician if the physician is continuously involved in a single case with a CRNA. No payment is made under the CRNA fee schedule for the services of the CRNA unless it is determined that it was medically necessary for the CRNA to be involved in the case.

It has been reported that anesthesiologists will bill using the AA modifier even though they are outside the operating room performing other activities, such as pain blocks, doing pre or post operative evaluations, or administering and/or monitoring a labor epidural. For the anesthesiologist to bill using the AA modifier under these circumstances, he must be physically present in the operating suite while the CRNA is attending to the case. If the anesthesiologist is not continuously involved with the

case, then it is considered neither personally performed nor medically directed. The carrier has the discretion to determine how much to recognize for the CRNA service based on the fact that part of the time the CRNA's services are overseen by the anesthesiologist and the remainder of the time, the CRNA is functioning as a nonmedically directed CRNA.

MEDICARE Newsletter [LOGO] BlueCross BlueShield of Minnesota

For Part B Providers April 1994 Number 44

Your Monthly Update of Medicare News

THE MEDICAL DIRECTOR'S COLUMN

By Jack W. Alexander, M.D.
Medicare Medical Director

Title: Diagnostic Mammography

This newsletter article is going to be brief but I want the chance to mention several things. First, I have revised the Diagnostic Mammography policy that was printed in the last newsletter. The policy that was published last month was a description of the national coverage guidelines and the ICD-9 codes that we have been using in the past. After publication, I realized that some changes were necessary. The most significant changes include the addition of diagnostic codes for secondary malignant neoplasms, neoplasms of uncertain behavior, and a "V" code for asymptomatic patients.

The reason for the addition of the secondary malignancy codes and the malignancy of uncertain behavior is that physicians often order mammograms on women who present with this clinical scenario. The purpose is to exclude breast cancer as the primary malignancy.

I added the "V" code. V76.1, to allow you to bill for the situation described by the third bullet in the "Description" section of the policy. In circumstances where the physician recommends a mammogram for reasons or diagnoses other than those listed in the policy this ICD-9 code should be used.

CAC Meeting

Our Carrier Advisory Committee meeting was held here at Blue Cross on February 17, 1994. Attendance was good and we had lively discussions on a number of topics. I presented two new policies which opened the comment. The policies include "Cardiac Event Recorder (93625)" and "Prostate Specific Antigen (3415)". If you are interested in receiving copies of these policies during the comment period please contact your CAC representative or contact me directly (see below).

Duluth Visit

On February 28th Pat Heald, Lori Ellis, and I had the opportunity to visit the Duluth Clinic. We spoke with physicians, clinic administrators, and billing personnel. We feel the meeting was very productive and helped us understand each others concerns. If you are interested in having us visit your clinic please feel free to contact me. You can reach me either at the address on this Newsletter or by phone at 612-456-1340.

MEDICARE FEE SCHEDULE CHANGES

The following changes have been made to the Medicare Fee Schedule Data Base. These changes will be effective April 1, 1994.

Procedure Changes

52332 Bilateral surgery indicator changed from a "O" to "1" – Payment adjustment for bilateral procedures applies if code is billed with the bilateral modifier (-50). Payment based on the lower of the billed

amount or 150% of the Medicare fee schedule amount.

69210 Bilateral surgery indicator changed from a "O" to "2" – Payment adjustment for bilateral procedures does not apply. RVUs are based on the procedure being performed as a bilateral procedure. Procedures in this category include services for which the code descriptor specifically states that the procedure is bilateral: procedures that are usually performed as bilateral procedures; or procedures for which the code descriptor indicates the procedures may be performed either unilaterally or bilaterally. Payment is based on the lower of the billed amount or the Medicare fee schedule amount.

92985 Global Period changed from "0" to "90" – days.

ANESTHESIA PAYMENT POLICIES: CLARIFICATION

The Health Care Financing Administration (HCFA) recently issued clarification in regard to the policies that apply when: (1) the starting point of one anesthesia procedure and the ending point of a second anesthesia procedure are the same (or medically directed anesthesia procedures; and (2) an anesthesiologist and a CRNA are both involved in a single anesthesia procedure.

1) Two concurrent procedures are recognized if there are two anesthesia procedures each of which is being performed by a CRNA, and the ending point of procedure A is the same as the starting point of procedure B. If, for example, an anesthesiologist is involved with two procedures, and one anesthesia procedure ends at 10:00 a.m. while the second procedure begins at 10:00

a.m., this case would be considered to be two medically directed procedures (reported with the "QJ" modifier).

2) Under federal regulations, an anesthesia procedure is considered personally performed by the physician if the physician is continuously involved in a single case with a CRNA. No payment is made under the CRNA fee schedule for the services of the CRNA unless it is determined that it was medically necessary for the CRNA to be involved in the case.

It has been reported that some anesthesiologists have billed using the "AA" modifier even tough [sic] they are outside the operating room performing other activities, such as pain blocks, doing pre- or post-operative evaluations, or administering and/or monitoring a labor epidural. For the anesthesiologist to bill using "AA" modifier under these circumstances, he or she must be physically present in the operating suite while the CRNA is attending to the case. If the anesthesiologist is not continuously present in the operating suite while the CRNA is attending to the case, then it is considered neither personally performed nor medically directed. In these instances, the anesthesiologist may not bill using the AA modifier. The CRNA may bill for the service as personally performed (QZ).

If an anesthesiologist has been paid for personally performing an anesthesia service when he or she was not continuously present, and the CRNA's claim was denied, payment may be made to the CRNA if it is brought to our attention that the anesthesiologist was not continuously present during the single procedure. Please attach any supporting documentation, including the anesthesia log

and a statement that the anesthesiologist was not continuously present.

[LOGO]
HealthSpan

March 12, 1993

Mr. Patrick Donohue
The Travelers
8120 Penn Ave. South
Bloomington, MN 55431

RE: Anesthesia Reimbursement

Dear Mr. Donohue:

The purpose of this letter is to confirm with you prior discussions relating to the standards for billing for the services of anesthesiologists (MDAs) and anesthetists (CRNAs). HealthSpan hospitals have received several letters in the past in which you requested to be reimbursed for payments previously made by the medicare program to the hospital on the grounds that the MDAs had billed and received payment for those services and that consequently the hospital should not have billed for the CRNA services. In an effort to ensure compliance with the appropriate Medicare rules and regulations and clarify any misunderstandings that may exist with respect to billing, I will set forth our understanding – based on previous conversations with you and other government entities or representatives – of the billing process.

As a general rule, an MDA may only be paid for services in one of two settings. The first scenario involves the personal delivery of the service by the MDA. The second involves the activity of the MDA in supervising (medical direction) two to four concurrent procedures in which the CRNAs deliver much of the service and the MDAs supervise the SRNAs and assist in the most difficult aspects of the anesthesia procedure.

The hospital is not entitled to reimbursement in those situations which the MDA personally delivered the service (1:1) even if the CRNA assisted in the process. The only exception to this rule is in exceptionally difficult cases that require the services of both the MDA and the CRNA. In this situation, the MDA would be able to bill for personally delivering the service and the hospital would be entitled to be reimbursed for the CRNA services.

The difficult question comes in determining when the MDA has personally delivered the service.

It is our understanding that in order to qualify for reimbursement for the personal delivery (1:1) of a service, the MDA must be "continuously present with the CRNA (if a CRNA is also involved) for those services the anesthesiologist does not personally perform, and the anesthesiologist can not be involved in any other anesthesia procedure." This means that the anesthesiologist either must personally perform all of the services related to the anesthesia procedure (including the history and physical, the induction, the monitoring, the emergence and other activities related to the anesthesia) or the MDA must have been continuously present in the operating room if the CRNA delivered any services. If the MDA does not perform all of the services or remain continually present in the operating room, the MDA has not personally delivered the service and is not entitled to bill for the service on a 1:1 basis because the service was not personally delivered. It should also be noted that the MDA is not entitled to bill for supervising a CRNA in this instance unless there was a concurrent case.

The anesthesiologist is also entitled to reimbursement on a reasonable charge basis for medical direction of CRNAs

furnished in concurrent procedures. In order to qualify for reimbursement for medical direction on concurrent cases, the MDA must (1) perform a pre-anesthesia examination and evaluation; (2) prescribe the anesthesia plan; (3) personally participate in the most demanding procedures in the anesthesia plan, including indiction and emergence; (4) insure that any procedure in the anesthesia plan that he or she is performed by qualified individuals (CRNAs); (5) monitors the course of anesthesia administration at frequent intervals; (6) remains physically present and available for immediate diagnosis and treatment of emergencies; and (7) provides indicated post-anesthesia care. If the foregoing criteria are not met, the MDA should not be billing for concurrent supervision.

It should also be noted that anesthesiologists who are part of a group practice may fill different components of the foregoing concurrent supervision reimbursement requirements and personal delivery requirements. However, the medical record must indicate that the services were rendered by physicians and identify the specific physicians or MDAs who rendered the services.

While I believe that the foregoing accurately reflects the state of the law, I would like to provide several examples and our conclusions with respect to how these should be billed. Please indicate whether or not you agree with our conclusions.

Example 1:

Procedure A and Procedure B both begin at 8:00 A.M. in adjoining operating rooms. A single MDA supervises the administration of the anesthetic by the CRNAs, participates in the most difficult portions of the anesthesia plan, including induction and emergence, monitors the course of

administration at frequent intervals and remains physically present in the operating suite to be immediately available in either operating room for the immediate diagnosis and treatment of emergencies.

It is our understanding that in the foregoing situation, the MDA would be entitled to bill for medical direction of the CRNAs. In addition, the hospital would be entitled to reimbursement for the CRNA services.

Example 2:

The activities performed by the MDA and the CRNA are the same as in Example 1 but there is no Procedure B occurring. Only Procedure A is being done meaning that there is only one operating room and one surgery.

In assuming that the same level of services were provided as above, it is our understanding that the MDA would not be permitted to bill for the service because (1) the MDA did not personally deliver the service, and (2) there were no concurrent procedures. In this situation, the hospital would be entitled to bill for the CRNA services but the MDA would not be entitled to bill at all.

Example 3:

The facts are the same as in Example 1 only the MDA's participation in the process is limited to performing the pre-anesthesia examination and evaluation prior to the procedure, remaining in the operating suite (as opposed to being continuously in the operating room), and monitoring the patient in the recovery room.

In this situation, the MDA would not be entitled to bill because the MDA did not fulfill all the requirements for supervision.

Example 4:

There is a single procedure in which both the MDA and the CRNA are continuously present. The MDA remains in the operating room and a continual active participant in the delivery of the anesthesia service throughout the operation. This is not a particularly difficult case and the service could have been provided without the assistance of the CRNA.

In the foregoing situation, it is our understanding that the MDA has personally delivered the service because he has remained continuously present in the operating room and/or actually performed most of the anesthesia services. Since the procedure was not a difficult one, the hospital is not entitled to the reimbursement for the CRNA services even though the CRNA may have assisted the MDA in various aspects of providing the anesthesia.

Example 5:

The facts are the same as in Example 4 except for this is an extremely difficult procedure requiring the services of both the MDA and the CRNA.

In this situation, the MDA would be entitled to bill one-to-one for personal delivery of the services, and the hospital would also be entitled to be reimbursed for the CRNA services.

Example 6:

Procedure A commences at 8:00 A.M. in operating room 1. The MDA is not personally delivering the service but rather is supervising the delivery of the service. Procedure A ends at 10:00 A.M. Procedure B commences in the adjoining operating room at 9:55 A.M. Again, the MDA is

not personally delivering the services but rather is supervising a CRNA who actually provides most of the service.

In this situation, the MDA would again not be entitled to payment for the service or supervision because the cases were not considered concurrent. Our understanding is that concurrency does not exist if there is five or less minutes of overlap of the cases. However, if the facts were the same as above but Procedure B started at 9:50 rather than at 9:55, the procedures would have been viewed as concurrent and the MDA would have been entitled to bill for concurrent supervision of the two cases.

Please review this letter carefully and respond with your conclusions relating to the accuracy or correctness of our interpretation of appropriate billing procedures. It is only after we have a clear understanding of how you interpret the billing requirements for anesthesia services that we can move to correct any deficiencies in the billing process that might exist.

If you have questions with regard to this matter, please feel free to call me at 612-574-7738.

Sincerely,

HEALTHSPAN HEALTH
SYSTEMS CORPORATION

/s/ Daniel R. Roach
Daniel R. Roach
Senior Attorney

MEDICARE

March 25, 1993

Daniel R. Roach
Senior Attorney
HealthSpan
2810 57th Avenue North
Minneapolis, MN 55430

Dear Mr. Roach:

I have received your letter of March 12, 1993 regarding "Anesthesia Reimbursement".

Your understandings of MDA and CRNA Medicare billing rights are essentially correct with one clarification. Instances where an MDA and a CRNA are both involved in a single case with no concurrency, the MDA's obligation is continuous involvement with the procedure, rather than, continuous presence with the CRNA as cited in your letter. Continuous involvement carries the same requirement as medical direction, one of which is that the MDA be present in the operating suite and available for diagnosis and treatment of emergencies.

Having made the above clarification, I offer my responses to your examples. My responses all assume that the MDA has met the medical direction requirements of personal performance of a pre-anesthesia exam and evaluation, prescription of the anesthesia plan, participation in the most demanding procedures of the anesthesia plan including induction and emergence, monitoring the course of anesthesia administration at intervals and providing indicated post-anesthesia care.

Example 1: I agree with your conclusion.

Example 2: I disagree with your conclusion because the MDA remained personally involved having rendered the required personal services and medically-directed delivery of the others.

Example 3: I agree with your conclusion, The MDA was deficient in not having personally participated in the most demanding procedures of the anesthesia plan including induction and emergence and in not having monitored the course of anesthesia administration at intervals.

Example 4: I agree with your conclusion.

Example 5: I agree with your conclusion and, as long as we (the Medicare Carrier), concur with the medical need for both participants, both Medicare claims will be covered.

Example 6: I disagree with your conclusion because concurrency is defined in terms of any overlap. In either of the timeframes that you cited, two concurrent procedures are involved and should be billed by the MDA accordingly.

I hope that my letter helps to achieve the clear understanding of anesthesia reimbursement that you seek. If more information is needed, please contact me again.

Yours truly,

/s/ Patrick Donohue
Patrick Donohue
Unit Manager

PD:dv

From: GE86 – HCFACHI Date and time 07/27/93 10:11:43
To: 00621E – HCFACHI 00103E – HCFACHI
007102E – HCFACHI 00220E – HCFACHI
10240E – HCFACHI 00951E – HCFACHI
16360E – HCFACHI

From: JIM CUCA
Policy Specialist/COB
(312) 353-3822

Subject: Anesthesia Procedures – CO Memorandum

We are sending to you via PROPS a memorandum from BPD which clarifies the policies involving two anesthesia scenarios: (1) one anesthesia procedure begins at the same time a second procedure begins; (2) an anesthesiologist and a CRNA are both involved in the same procedure. The file name for the memo is NESFOLL.WF.

If there are any questions, please call me at (312) 353-3822 or Alice Wiley at (312) 353-9851.

cc: GK40 – HCFACHI Arney, Steve

GK40 – HCFACHI Arney, Steve

CC: ADMINISTRATIVE
PERSONNEL

REFER TO: FQA-541

Director
Office of Payment Policy, BPD

Anesthesia Payment Policies

All Associate Regional Administrators
for Medicare

We have been asked to clarify the policies that apply when: (1) the starting point of one anesthesia procedure and the ending point of a second anesthesia procedure are the same for medically directed anesthesia procedures; and (2) an anesthesiologist and a certified registered nurse anesthetist (CRNA) are both involved in a single anesthesia procedure.

We would recognize two concurrent procedures if there are two anesthesia procedures each of which is being performed by a CRNA, and the ending point of procedure A is the same as the starting point of procedure B. If, for example, an anesthesiologist is involved with two procedures, and one anesthesia procedure ends at 10:00 while the second procedure begins at 10:00, then we will consider this case to be two procedures medically directed by the anesthesiologist. Thus, these procedures would be reported with the QJ modifier and not the AA modifier used for personally performed procedures. Consequently, each of these procedures would be subject to the 10 percent base unit reduction and would be permitted half the time units of a personally performed procedure.

Under the regulations, an anesthesia procedure is considered personally performed by the physician if the physician is continuously involved in a single case with a CRNA. No payment is made under the CRNA fee schedule for the services of the CRNA unless it is determined that it

was medically necessary for the CRNA to be involved in the case.

It has been reported that anesthesiologists will bill using the AA modifier even though they are outside the operating room performing other activities, such as pain blocks, doing pre or post operative evaluations, or administering and/or monitoring a labor epidural. For the anesthesiologist to bill using the AA modifier under these circumstances, he must be physically present in the operating suite while the CRNA is attending to the case. If the anesthesiologist is not continuously involved with the case, then it is considered neither personally performed nor medically directed. The carrier has the discretion to determine how much to recognize for the CRNA service based on the fact that part of the time the CRNA's services are overseen by the anesthesiologist and the remainder of the time, the CRNA is functioning as a nonmedically directed CRNA.

Charles R. Booth

cc:
Stewart Streimer, BPO
Office of Issuances
Field Operations

FQA-541:JMPNAS/x64507:TRINA/x65702
DATE: 7/15/93/FINAL:
DISC:TRINA#3/DOC:ANESFOLL.JME/FILE
CODE:CRNA
CATCS Control #:

ProSTAT

ResourceGroup

ANALYSIS OF

CARRIER CORRESPONDENCE

February 1997

Prepared by:

Brenda Morrow

ProSTAT

Resource Group

6900 College Boulevard • Suite 1000

Overland Park, Kansas 66211

(913) 663-5588

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

Personal Background

I, Brenda Morrow of ProSTAT Resource Group, prepared this study. My experience related to Medicare Part B issues includes employment by Blue Cross and Blue Shield of Kansas City in its Medicare Part B division from 1980-1986. During that time, I was involved in multiple aspects of Medicare claims processing and ended my tenure there as Manager of Claims Processing. Since 1986, I have

worked as a consultant to physicians and other health care providers on Medicare Part B and other insurance billing issues. In this capacity, I have worked with anesthesia practices on billing and compliance issues. I am editor of an anesthesia newsletter, *Perspectives,* and co-author of an anesthesia text, *Getting Paid for Anesthesia.*

I have been associated with ProSTAT since its inception in 1990 and am currently Director of Special Projects. My curriculum vitae is included as Attachment 5 to this report. I have been retained by defense counsel in litigation involving CRNAs in Federal District Court in Minnesota.

Scope of the Study

The purpose of this study was to determine how the Health Care Financing Administration's (HCFA) guidelines regarding payment for anesthesia services provided when an anesthesiologist and a CRNA are involved in a single case have been conveyed by Medicare Part B carriers to physicians and other providers.

To begin this study, I prepared a written request for copies of all Carrier's Manual provisions, provider bulletins, newsletter articles or other written communication related to anesthesia billing and reimbursement issues that were issued to the physician and/or provider community from January 1, 1989, forward. This request was sent to all Medicare Part B carriers and was made in accordance with the provisions of the Freedom of Information Act (FOIA).

A copy of the written FOIA request and a list of all carriers to whom it was sent are shown as Attachment 1 to

this report. FOIA requests were sent to the 40 insurance companies listed as Medicare Part B carriers in HCFA's 1995 *Intermediary and Carrier Directory*. Of these 40 carriers, two are no longer active Part B carriers (Blue Cross Blue Shield of Minnesota and Aetna in New Mexico) and one did not respond at all (Blue Cross and Blue Shield of Arkansas). The remaining 37 carriers (97%) have responded to the FOIA request as of the date of this report.

As responses were received, I noted that a significant number of unrelated carriers published articles in late 1993 related to billing for medical direction of a CRNA on a single case. These individual newsletter articles were similar enough to indicate that they were based on communication from the Health Care Financing Administration and were not independently developed by each carrier. To verify this, I sent a second FOIA request to each of these carriers to obtain copies of the HCFA communication or other source document that was the basis for the articles.

A copy of the second written FOIA request and a list of all carriers to whom it was sent are shown as Attachment 2 to this report. FOIA second requests were sent to 16 carriers and 14 responses (88%) have been received as of the date of this report. (Responses from CIGNA for the states of North Carolina and Idaho were provided by CIGNA in Tennessee.)

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

These responses are sufficient to indicate that the fall 1993 carrier bulletins were derived from a July 1993 memorandum from Charles Booth at HCFA's Central Office. This memo was sent to the Associate Regional Administrators at HCFA's Regional Offices. The Regional Offices then distributed the information to many, if not all, of the Part B carriers. Attachment 3 includes a copy of the July 1993 HCFA memorandum and several examples of carrier bulletins that are derivatives of that memo.

Responses to both FOIA requests were evaluated on a carrier-by-carrier basis to determine whether the carrier provided instructions to physicians regarding how anesthesia services provided when an anesthesiologist and a CRNA are involved in a single case are to be reported by the physician and/or paid by the carrier. Responses from carriers who did address this issue in their physician correspondence were further evaluated to determine whether their instructions and policies were consistent from carrier to carrier.

Detail of the instructions provided by the carriers who addressed this issue are shown as Attachment 4 to this report.

Findings

1. Between 1989 and the date of our survey (late 1996), 33 of the 37 carriers (89%) who responded to our initial FOIA request conveyed guidelines to physicians related to billing for the situation in which a physician and a CRNA are both involved in a single

case. Four carriers apparently did not provide any newsletter guidelines related to this issue (Blue Cross Blue Shield of Kentucky, Blue Cross and Blue Shield of Rhode Island, General American Life Insurance Company [Missouri] and Triple-S [Puerto Rico]).

2. Between 1989 and the fall of 1993, at least 18 of the 37 carrier responses (49%) contained guidelines for billing services provided by a physician and a CRNA in a single case. Most of this correspondence reflects a portion of the Medicare Carriers Manual instruction at Section 8310.B which says, "Where an anesthesiologist and an anesthetist are both involved in a single anesthesia service, the service is consthesiologist. No separate payment is ordinarily recognized for the anesthetist's service." None of these carriers expanded on the definition of the term "involved."

   The language of Section 8310.B is reflected in pre-September 1993 correspondence from:

   - Aetna (Georgia)
   - IASD (Iowa)
   - Blue Cross and Blue Shield of Kansas
   - Travelers [now MetraHealth] (Minnesota)
   - Travelers [now MetraHealth] (Mississippi)
   - CIGNA (North Carolina)
   - Nationwide (Ohio)
   - Aetna (Oklahoma)

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

- Blue Cross and Blue Shield of Pennsylvania [now XACT Medicare Services]
- CIGNA (Tennessee)
- Blue Cross and Blue Shield of Texas
- Travelers [now MetraHealth] (Virginia)
- Aetna (Washington)

Pre-September 1993 correspondence from four additional carriers did not reflect Section 8310.B verbatim. These carriers, however, indicated that *supervision, direction* or *medical direction* of one CRNA was considered to be a service personally performed by the physician. These carriers include: WPS Health Insurance (Wisconsin), Aetna (Arizona/Nevada), CIGNA (Idaho), and Aetna (OR, AK).

The response from Blue Shield of California was the only one that included pre-1993 guidelines that the physician must be "personally and continuously involved" in delivering a service in order to bill for it as personally performed. This statement was published in early 1992 and corresponds to HCFA's addition of Section 15018.B to the Medicare Carriers Manual following implementation of the physician fee schedule. Section 15018.B states that "(Payment at Personally Performed Rate) . . . if . . . the physician was personally and continuously involved in a single anesthesia procedure performed by a . . . CRNA. . . ."

3. Twenty-two of the 37 responding carriers (59%) plus non-responding Blue Cross and Blue Shield of Minnesota (as shown in documents supplied to us by defense counsel) have published statements since 1989 that indicate that payment will be made at the personally performed rate to an anesthesiologist who medically directs or supervises a CRNA, or is assisted by a CRNA, on a single case. Twelve of these 23 carriers (52%) published such statements in 1995 and 1996. Table 1 on the next two pages lists the carriers who have published post-1989 references indicating that payment at the personally performed rate will be made to the anesthesiologist for "medical direction" or "supervision" of a CRNA on a single case. Complete details of each article referred to can be found in Attachment 4.

Table 1: Medical Direction/Supervision of a CRNA on a Single Case/Personally Provided Service

Carrier	*Date*	*Statement*
1. Blue Cross Blue Shield (AL)	April 1996	"If the anesthesiologist ... supervises only one CRNA, the AA modifier is used and the anesthesiologist receives the entire Medicare payment ..."
2. Aetna (AZ/NV)	Spring 1993 October 1995	"Anesthesia services ... involving the direction of only one anesthetist is considered to be personally performed ..."
	Spring 1993	"No claim should be filed for CRNA/AA services where only one CRNA/AA is directed. This is considered to be personally

		performed by the physician, only the physician should bill.
	July 1995	"AA ... Direction of one anesthetist/resident CRNA ... "
	October 1995	"When an anesthesiologist and an anesthetist are both involved in a SINGLE anesthesia service, the service is ... performed by the anesthesiologist ... "
	October 1995 1996	"Anesthesia services ... involving physician direction of only one anesthetist are reported by ... Modifier AA."
3. Blue Cross Blue Shield (CA)	Undated	"Medically directed: Use the medically directed conversion factor to determine payment where the anesthetist is medically-directed by an anesthesiologist as follows: "Where an anesthesiologist and an anesthetist are both involved in a single anesthesia service, the service is considered personally performed by the anesthesiologist ... "
4. Transamerica (CA)	September 1995	"Charges for the medical direction of CRNAs ... paid to, the physician anesthesiologist. Both CRNA/AA charges and anesthesiologists charges MAY be payable for the same procedure ... "

		September 1995	"Use one of the following modifiers to indicate the role of the billing physician . . . : AE – Anesthesiologist directed one anesthesia service"
5.	Aetna (Georgia)	Undated	"If a physician directs only one anesthetist, the claim should be billed as though the physician were rendering the service himself . . . "
		July 1995	"AA . . . Direction of one anesthetist/resident CRNA . . . "
6.	Aetna (Hawaii)	July 1995	"AA . . . Direction of one anesthetist/resident CRNA . . . "
7.	CIGNA (Idaho)	March 1993	"AA – Physician personally performed. (Also use AA when the anesthesiologist medically directs only one CRNA.)"
8.	IASD (Iowa)	June 1993	"AA – indicates . . . supervision of one CRNA."
9.	C & S (ME. NH. VT. MA)	July 1996	"If an anesthesiologist supervises only one CRNA performing one anesthesia session, Medicare pays the anesthesiologist as . . . personally performed . . . "
		November 1993	"Under the regulations, an anesthesia procedure is considered personally performed by the physician if

		said physician is continuously involved in a single case with a CRNA .... Anesthesiologists should bill using the AA modifier although they are outside the operating room . . . "
10. Blue Cross Blue Shield (MN)	June 1992	"Medical Direction of One CRNA: Supervision of one . . . CRNA . . . is considered to have been personally performed on the part of the physician . . . "
	January 1993	"Supervision of CRNA in a Single Case: Supervision of one CRNA . . . is considered to have been personally performed on the part of the physician . . . "
11. Blue Cross Blue Shield (Montana)	December 1994 May 1994 May 1995 May 1996	"If a physician directs only one CRNA . . . in a single procedure . . . the physician should bill as if he personally performed the procedure . . . " "Prior to 1996, . . . where an anesthetist and a anesthesiologist are both involved in a single anesthesia service, the service is considered personally performed by the anesthesiologist . . . "
12. Empire Medicare Services (New York)	1996	"The physician . . . will be paid at the personally performed rate if . . . the physician medically directed one CRNA."

		"... Medical supervision of one CRNA must use modifier 'AA'."
		"AA – ... medical direction of one CRNA ..."
13. CIGNA (NC)	August 1991	If an anesthesiologist ... supervises only one CRNA during the entire procedure, he may use an 'AA' modifier ... Regulations state that the anesthesiologist must be in the immediate vicinity and available to the CRNA ..."
	March 1993	"... Also use AA when anesthesiologist medically directs only one CRNA."
14. Nationwide (OH/WV)	September 1989 January 1996	"Medical direction of One Anesthetist – When an anesthesiologist and an anesthetist are both involved in a single anesthesia service ..."
15. Aetna (OK/NM)	July 1995	"AA ... Direction of one anesthetist/resident CRNA ..."
16. Aetna (Oregon, Alaska)	January 1989 January 1996	"When the anesthesiologist directs only one CRNA, the anesthesiologist will be reimbursed 1 unit for every 15 minutes, no reimbursement will be made for the CRNA's services ..."
	July 1995	"AA ... Direction of one anesthetist/resident CRNA ..."

17. XACT (PA)	October 1987	"Anesthesia Procedure Performed Personally by Physician – . . . the same 15-minute time unit intervals apply when an anesthetist assists the physician in the care of a single patient."
18. CIGNA (TN)	March 1993	"AA – . . . Also use AA when the anesthesiologist medically directs only one CRNA."
19. Blue Cross Blue Shield of Texas	January 1992	" . . . If an anesthetist assists the physician in the care of a single patient, the service is considered personally performed by the physician . . . "
20. Blue Cross Blue Shield of Utah	September 1995	" . . . when an anesthesiologist is directing only one CRNA, only the anesthesiologist can bill and be paid . . . "
	July 1996	" . . . if the anesthesiologist is directing only one CRNA, only the anesthesiologist will file a claim to Medicare. The anesthesiologist would need to reimburse the CRNA."
21. Metra-Health (VA)	March 1993	"Modifier 'AA' billed by the anesthesiologist indicates that . . . they medically directed only one CRNA . . . "
22. Aetna (Washington)	March 1989	"The following modifiers must be used with physicians services . . . AC – Medical direction of one procedure . . . "

	October 1989	" . . . Supervision of 1 CRNA
23. WPS (Wisconsin)		. . . is considered to have been personally performed on the part of the physician."
	January 1991	"When an anesthesiologist is medically directing one CRNA . . . the service is considered personally performed by the anesthesiologist . . . "

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

4. In the fall of 1993, sixteen of the responding carriers published articles that were based on a HCFA memorandum to HCFA regional administrators in July 1993. This memo was in turn conveyed from the regional offices to the local Medicare Part B carriers. These guidelines are:

> "Under the regulations, an anesthesia procedure is considered personally performed by the physician if the physician is continuously involved in a single case with a CRNA. No payment is made under the CRNA fee schedule for the services of the CRNA unless it is determined that it was medically necessary for the CRNA to be involved in the case.
>
> "It has been reported that anesthesiologists will bill using the AA modifier even though they are outside the operating room performing other activities, such as pain blocks, doing pre or post operative evaluations, or administering and/or monitoring a labor epidural. For the anesthesiologist to bill using the AA modifier under these circumstances, he must be physically present in

the operating suite while the CRNA is attending to the case. If the anesthesiologist is not continuously involved with the case, then it is considered neither personally performed nor medically directed. The carrier has the discretion to determine how much to recognize for the CRNA service based on the fact that part of the time the CRNA's services are overseen by the anesthesiologist and the remainder of the time, the CRNA is functioning as a nonmedically directed CRNA."

Table 2 lists ten carriers who reprinted the July 1993 HCFA memorandum in their newsletters in late 1993. These carriers did not expand on the HCFA memo or apply interpretive guidelines. None of the 37 responding carriers, including the ten in Table 2, have defined "continuously involved," "operating room" or "operating suite" in any of the correspondence with physicians which they supplied to us. (Non-responding Blue Cross and Blue Shield of Minnesota, in documents provided by defense counsel, reprinted the July 1993 HCFA memo in its April 1994 newsletter, omitting the material concerning "carrier discretion.")

Table 2: Carriers Reprinting the July 1993 HCFA Memorandum

Carrier	*Entire HCFA memo reprinted*	*"Carrier discretion" omitted*	*Carrier comment added*
Blue Cross Blue Shield (Alabama)	Yes	No	No
MetraHealth (Connecticut)	Yes	No	No
CIGNA (Idaho)	No	Yes	No
IASD (Iowa)	Yes	No	No

MetraHealth (Mississippi)	No	Yes	No
MetraHealth (Minnesota)	Yes	No	No
Blue Cross Blue Shield of Western NY	Yes	No	No
CIGNA (North Carolina)	No	Yes	No
Palmetto (South Carolina)	Yes	No	No
MetraHealth (Virginia)	Yes	No	No

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

Five other carriers published the 1993 HCFA memorandum but altered it and/or added locally-developed interpretation:

- Health Care Service Corporation (Illinois) altered the HCFA statement by eliminating the sentence that begins. "For the anesthesiologist to bill using the "AA" modifier under these circumstances . . . " and concluded that "if the anesthesiologist is not continuously involved with the case, it is considered neither personally performed nor medically directed." The carrier does not state whether it considers "continuously involved" to mean the physician is continuously present in the operating room as opposed to continuously present in the operating suite.

- Blue Cross Blue Shield of North Dakota altered the HCFA statement by paraphrasing it and concluding that HCFA's statement that "if the anesthesiologist is not continuously involved with the case, then it is considered neither personally provided nor medically directed" means that anesthesiologists are not to use

modifier AA if they are outside the operating room during the case.

- AdminiStar Federal (Indiana) explicitly prohibited physicians from billing for personally provided services unless they were personally present in the operating room from induction to emergence. AdminiStar was the only carrier to publish an extensive variation of the HCFA text.

- XACT Medicare Services, the carrier for Pennsylvania, changed the term "operating suite" to "operating room" and indicated that the statement meant that a personally provided service (modifier AA) could be reported only when the anesthesiologist did not leave the operating room.

- C & S Administrative Services, the carrier for Maine, New Hampshire, Vermont and Massachusetts, printed only the first paragraph of the HCFA memo and indicated that "Anesthesiologists should bill using the AA modifier although they are outside the operating room performing activities such as: pain blocks, pre- or post-operative evaluations . . . For the anesthesiologist to bill using the AA modifier under these circumstances, he/she must be physically present in the operating suite while the CRNA is attending the case . . . ".

Blue Cross and Blue Shield of Florida published in its September/October 1993 carrier bulletin an instruction to providers related to the use of the AA modifier that may have been based on the July 1993 HCFA memorandum due to its timing. The Florida carrier was not able to supply the source document for this article, however, because the document apparently had been destroyed in a fire.

Analysis of Carrier Correspondence With Physicians Regarding Billing for Medical Direction of a CRNA on a Single Case

Summary

1. Prior to the fall of 1993, 49% of the carriers responding to this survey had notified physicians of the provisions of Section 8310.B. of the Medicare Carriers Manual either verbatim or in substance. These carriers indicated that if an anesthesiologist was "involved in," "medically directed," "directed," or "supervised" a CRNA in a single case, payment was to be made to the anesthesiologist at the personally performed rate.

   The remaining responding carriers did not provide copies of pre-September 1993 correspondence related to this issue.

2. Section 15018.B supplemented Section 8310.B in the Carriers Manual in 1992. At that time, only one carrier among those responding discussed the change from "involvement" to "personal and continuous involvement" in connection with an anesthesiologists' duties in a 1:1 case.

3. Prior to the fall of 1993, there were no references noted to personal and continuous presence in the operating *room* as a requirement for deeming that the anesthesiologist personally provided the service when the anesthesiologist and an anesthetist were both involved in a single anesthesia service.

4. A July 1993 HCFA Central Office memorandum to all HCFA Associate Regional Administrators was published verbatim by ten carriers in late 1993, and by Blue Cross and Blue Shield of Minnesota in April 1994. This directive also contained the term "continuous involvement" and referenced both an "operating suite" and an "operating room." None of these carriers

defined any of the terms used in the HCFA memo apart from the context of the HCFA memo.

5. Prior to 1996, five carriers published their own versions of the July 1993 HCFA memorandum and added local variation to the text. One carrier based its guidelines for paying for personally provided services on the premise that the physician is "continuously involved" in the case with the CRNA, but did not define "continuous involvement." Three carriers changed the term "operating suite" to "operating room" and implemented a policy that the physician could not report modifier AA if he or she left the room. The fifth carrier interpreted the policy to mean that the AA modifier *was* to be used when the physician was outside the operating room but physically present in the operating suite throughout the procedure.

6. In 1996, at least three carriers indicated that their payment policy changed during that year. Blue Cross and Blue Shield of Montana stated that *prior to 1996*, payment was made at the personally provided rate when an anesthetist and an anesthesiologist were both involved in a single anesthesia service. In June, MetraHealth (Minnesota) stated that HCFA had *recently* provided clarification and indicated that failure to comply *after the date of the 1996 notice* could be considered fraud. MetraHealth (Mississippi) published a notice in August 1996 substantially similar to that published by MetraHealth (Minnesota).

Signed: Brenda Morrow Date: 2-27-97

REPORT OF JAMES F. ARENS, M.D.

I. BACKGROUND AND QUALIFICATIONS

A copy of my curriculum vitae is attached hereto and describes my background and qualifications. By way of summary, I have been an anesthesiologist since 1962. Since 1966, I have done almost exclusively cardiac and thoracic anesthesia. In 1986, I received the first certification issued in Critical Care Medicine by the American Board of Anesthesiology. Currently I am the Chief Executive Officer of UTMB Hospitals and Vice President for Clinical Affairs at The University of Texas Medical Branch (UTMB) in Galveston, Texas. From 1977 to 1990, I was Professor and Chair of the Department of Anesthesiology at UTMB and also Executive Director of the Operating Rooms at UTMB.

I am very familiar with the Medicare regulations governing anesthesiology as a result of my activities in the American Society of Anesthesiologists (ASA) which are described on my CV.

I have held various elected offices in the ASA, including serving as President from 1988-1989. Moreover, I have served on various committees including serving from 1974 to 1977 on the liaison Committee on Representation to American Association of Nurse Anesthetists. I also served from 1975 to 1980 on the Committee on Anesthesia Care Team. From 1975 to 1986 I also served on the Governmental Affairs Committee for the American Society of Anesthesiologists. While serving on the Governmental Affairs Committee, members of our committee met with HCFA representatives to discuss the ASA Guidelines that became the 1984 TEFRA regulations, now set forth at 42 C.F.R. 415.110. As a result, I know what the regulations

which reflect the ASA guidelines, were intended to require as described below. I remain involved in the ASA. Currently I am Senior Delegate from the ASA to the American Medical Association House of Delegates.

As described on my CV, I also served on numerous other committees and held other offices within the ASA. I remain familiar with the way anesthesia is practiced throughout Texas and in other areas of the country as a result of my work in the ASA and the American Medical Association.

II. BILLING MEDICARE WITH THE "AA" MODIFIER FOR A SINGLE CASE

The ASA guidelines that became the TEFRA regulations were intended to promote "good patient care", not requirements for billing. The intent of the ASA Guidelines was to implement certain requirements that would improve patient care. With regard to billing Medicare with the "AA" modifier for provision of anesthesia to a single patient, the Medicare regulations do not require the anesthesiologist to remain physically present in the operating room for the entire procedure. Moreover, the ASA Guidelines that became the TEFRA regulations were not intended to require physical presence at all times in the operating room of the anesthesiologist with the qualified anesthesia provider in a single case. That was not the standard of practice at the time the ASA Guidelines were discussed with HCFA representatives and we had no intention of changing the way anesthesia care was delivered by an anesthesia care team.

42 C.F.R. 414.45c(1)(vi) states that the anesthesiologist must be "continuously involved" in a single case. That

does not mean that the anesthesiologist must remain physically present in the operating room at all times with the qualified anesthesia provider. If the anesthesiologist is immediately available for treatment of emergencies, the anesthesiologist is "continuously involved" and does not need to be in the operating room itself.

III. ROOM VS. SUITE

An operating room is distinct from an operating suite. An operating suite includes other areas beyond the operating rooms. Although the boundaries of the operating suite may vary from hospital to hospital depending on the layout of the hospital, typically it may include all of the operating rooms, the recovery rooms, holding area, offices, break area, supply rooms, doctors' lounge, nurses' lounge, and bathrooms. The operating suite is not just the sterile areas.

An operating room, on the other hand, refers to the individual room where the surgery for a single patient takes place.

IV. EMERGENCE FROM ANESTHESIA

For purposes of 42 C.F.R. 415.110(a)(1)(iii) (which is based on the ASA Guidelines), "emergence" is defined as the process of recovering from anesthesia. It does not equate to extubation. In those cases in which a patient is intubated, extubation may occur during emergence, and may to a demanding part of the anesthesia procedure depending on the patient and the anesthesia procedure performed, but it is not itself emergence. Most patients are extubated while asleep, so they have not fully emerged at the time of extubation. A patient is considered "emerged"

from anesthesia when that patent can control his or her reflexes.

42 C.F.R. 110(a)(1)(iii) requires an anesthesiologist to "personally participate" in emergence; it does not require "presence" at emergence. The level of involvement by the anesthesiologist varies in any particular procedure depending on many factors, including the number of concurrent cases, the nature of the surgical procedure, the condition of the patient, and the skills of the qualified anesthesia provider with whom the anesthesiologist is working. Because an anesthesiologist can medically direct up to four cases at a time, the anesthesiologist may not be in the room when a patient begins to emerge. 42 C.F.R. 415.110(a)(1)(iii) does not require that the patient be kept under anesthesia until the anesthesiologist returns.

Moreover, the ASA Guidelines and the regulations derived from them (now 42 C.F.R. 415.110) were never intended to require actual physical presence in the operating room but rather immediate availability throughout the period during which emergence occurs, which is a continuum. The requirement in 42 C.F.R. 415.110(a)(1)(iii) that the anesthesiologist "participate in" emergence was intended to permit the anesthesiologist to use his or her medical judgment to determine how best to participate in emergence in one room.

An anesthesiologist can participate in emergence by checking on the patient in the recovery room and being available at other times in the emergence continuum. 42 C.F.R. 415.110(a)(1)(vii) requires provision of indicated post-anesthesia care, which is different from checking on the patient in the recovery room. When we wrote that the anesthesiologist must provide indicated post-anesthesia

care, we intended to require the anesthesiologist to provide care when emergencies or other complications occur after surgery.

V. EXCEPTION TO MEDICAL DIRECTION TO PERMIT LABOR EPIDURALS

Labor epidurals are a relatively recent phenomenon. Hospitals started offering them to obstetrical patients in the early 1970's. Labor epidurals provide safe, effective, early pain relief for women in labor and they were shown to be very useful in managing high blood pressure in pregnant patients with pre-eclampsia (pregnancy-induced hypertension). Labor epidurals made for a much more controlled environment in the labor and delivery area, and they were a much improved substitute for analgesia that was previously often provided by high doses of drugs such as Demerol and Phenergan that could result in significant respiratory depression of the newborn, which can cause cerebral palsy.

While the labor epidurals presented a medical breakthrough, anesthesiologists were often unavailable or reluctant to perform them because of the low volume of obstetrical cases in certain hospitals and because the epidurals could not by definition be scheduled. The Medicare regulation that permits the anesthesiologist to perform a labor epidural without affecting concurrency was intended to encourage anesthesiologists to perform labor epidurals when they might otherwise be reluctant to do so.

In most hospitals, the labor and delivery area is on a different floor from the operating suite for reasons of privacy and access by families. Nonetheless, the Medicare

regulations specifically permit an anesthesiologist to perform labor epidurals while medically directing cases even though the obstetrical area may be on a different floor. The fact that the labor and delivery area is on a different floor does not mean that anesthesiologists there are not immediately available to return to an operating room if needed. For the same reason, in certain situations an anesthesiologist may be able to do rounds or participate in hospital meetings and still be available to return to the operating room as needed.

VI. HANDS-OFF FROM ONE ANESTHESIOLOGIST TO ANOTHER ARE COMMON IN GROUP PRACTICE

Anesthesiologists practicing in a group practice frequently transfer responsibility for cases from one member of the group to another. Handoffs can occur at any time during the procedure. Nothing in the Medicare regulations prohibits handoffs. Based on my work with the ASA Governmental Affairs Committee that drafted what became the 1984 TEFRA regulations, I know that we did not intend to restrict when handoffs could occur.

VII. ADVICE FROM LOCAL CARRIER VS. HCFA

HCFA has told the ASA for years when we have sought national clarification of policy issues that it would not issue that clarification and instead would defer to the discretion of the local carriers. An example is monitored anesthesia care where there is a multiplicity of interpretations issued by various carriers. Thus, Medicare policies have become a patchwork of varying interpretations that depend on the local carrier. It is therefore reasonable for

anesthesiologists to rely on interpretations from the local carrier.

VIII. PUBLICATIONS

See attached Curriculum Vitae.

IX. PRIOR TESTIMONY

I have not testified at trial in the past four years. I have given a few depositions in medical malpractice cases in the last four years but do not have available the details of these cases, all of which settled or dropped as far as I know.

X. LIST OF SOURCES RELIED UPON AND/OR CONSIDERED IN FORMING OPINIONS

1. Second Amended Complaint and third amended Complaint in Qui Tam case
2. 42 C.F.R. 415.110 (Conditions for Payment: Anesthesiology Services).

XI. COMPENSATION

I am charging $350 per hour plus expenses for my services in connection with this case. To date, I have billed approximately $1,400.

Dated: December 12, 1997

/s/ James F. Arens
James F. Arens, M.D.

CURRICULUM VITAE

NAME: JAMES F. ARENS, M.D.

DATE: March 20, 1997

PRESENT POSITION AND ADDRESS:

Vice President for Clinical Affairs
Chief Executive Officer, UTMB Hospitals
Professor, Department of Anesthesiology
The University of Texas Medical Branch
Galveston, TX 77555-0138

BIOGRAPHICAL:

DATE OF BIRTH:	April 20, 1934
PLACE OF BIRTH:	Hamal, Minnesota
CITIZENSHIP:	United States
HOME ADDRESS:	22 South Shore Drive Galveston, Texas 77551

EDUCATION:

UNDERGRADUATE:	Creighton University Omaha, Nebraska 1952-1955
GRADUATE:	Creighton University Medical School Omaha, Nebraska MD, 1955-1959
POSTGRADUATE:	Rotating Internship Tripler Army Hospital Honolulu, Hawaii 1959-1960
	Anesthesiology Residency Charity Hospital New Orleans, Louisiana 1960-1962

MILITARY:

USAF – 750th Hospital
Swindon, England
Chief of Anesthesiology
1962-1965

Travis Hospital
Travis, California
Chief of Anesthesiology
1965-1966

PROFESSIONAL AND TEACHING EXPERIENCE:

1. Director of Inhalation Therapy — 1967-1972
   Ochsner Foundation Hospital
   New Orleans, Louisiana

2. Director of Intensive Care Unit — 1968-1972
   Ochsner Foundation Hospital
   New Orleans, Louisiana

3. Director, Recovery Room — 1968-1972
   and Operating Room
   Ochsner Foundation Hospital
   New Orleans, Louisiana

4. Director of Anesthesia — 1968-1972
   Ochsner Foundation Hospital
   New Orleans, Louisiana

5. Visiting Anesthesiologist — 1968-1972
   Charity Hospital
   New Orleans, Louisiana

6. Assistant Professor of Surgery — 1968-1972
   Division of Anesthesiology
   Tulane University
   New Orleans, Louisiana

7.	Medical and Administrative Director of Operating Room Ochsner Foundation Hospital New Orleans, Louisiana	1969-1972
8.	Medical Director School of Inhalation Therapy Ochsner Foundation Hospital New Orleans, Louisiana	1971-1972
9.	Director of Operating Room University of Mississippi Medical Center Jackson, Mississippi	1972-1977
10.	Professor and Chairman Department of Anesthesiology University of Mississippi Medical Center Jackson, Mississippi	1972-1977
11.	Professor Department of Pharmacology University of Mississippi Medical Center Jackson, Mississippi	1972-1977
12.	Chief of Staff University of Mississippi Medical Center Jackson, Mississippi	1974-1976
13.	Consulting Staff Mississippi Methodist Rehabilitation Center Jackson, Mississippi	1975-1977

14. Professor and Chairman — 1977-1990
Department of Anesthesiology
Rebecca Terry White Chair — 1985-1991
in Anesthesiology
The University of
Texas Medical Branch
Galveston, Texas

15. Executive Director of — 1977-1990
Operating Rooms
The University of Texas Medical Branch
Galveston, Texas

16. Acting Executive Director — 1980-1981
of Inpatient Services
The University of Texas Medical Branch
Galveston, Texas

17. Medical Director — 1981-1982
Respiratory Therapy Department
School of Allied Health Sciences
The University of Texas Medical Branch
Galveston, Texas

18. Surgical Operating and Acute — 1981-1982
Care Support Services
Associate Administrator
The University of Texas Medical Branch
Galveston, Texas

19. Medical Coordinator for — 1982-1990
Surgical Operating and
Acute Care Support Services
The University of Texas Medical Branch
Galveston, Texas

20. Vice President for Hospital Affairs — 4/90 to 8/90
ad interim
The University of Texas Medical Branch
Galveston, Texas

21. Vice President for Clinical Affairs 1990-present
The University of Texas Medical Branch
Galveston, Texas

RESEARCH ACTIVITIES:

Throughout the chairmanship at UTMB, research was fostered in the Anesthesiology Department and during the last five years as Chairman, over two million dollars a year was funded in Anesthesiology Research. Research was actively supported for Drs. Joseph Gabel, Robert Drake, Robert Wolfe, Daniel Trabor, Thomas Nelson, Eugene Flowelien, George Kramer, Sharon Nelson, J. Jeffrey Andrews and others. This commitment to research excellence provided the support and milieu in which research excellence could and did exist. A national reputation was established for Malignant Hyperpyrexia. In addition, the influence of lung water in ARDS was widely studied, especially relating to osmotic and pulmonary capillary pressures.

COMMITTEE RESPONSIBILITIES:

National:

1. Committee on Scientific Exhibits 1970-1974
American Society of Anesthesiologists

2. Chairman, Committee on Panels 1971-1972
American Society of Anesthesiologists

3. Committee on Panels American 1972-1976
Society of Anesthesiologists

4. Chairman, Committee on Scientific 1973-1974
Exhibits American Society of
Anesthesiologists

5.	Liaison Committee on Representation to American Association of Nurse Anesthetists American Society of Anesthesiologists	1974-1977
6.	Committee on Governmental Affairs American Society of Anesthesiologists	1975-1986
7.	Committee on Anesthesia Care Team American Society of Anesthesiology	1975-1990
8.	Ad Hoc Committee on Self-Evaluation American Society of Anesthesiologists	1975-1978
9.	Appeals Committee American Board of Anesthesiology	1976-1981
10.	Chairman, Committee on Reimbursement ICU Services Society of Critical Care Medicine	1977-1990
11.	Joint Council on in-Training Examinations American Board of Anesthesiology	1977-1990
12.	Task Force for Certification of Special Competence in Critical Care Medicine American Board of Medical Specialties	1978-1980
13.	In-Training Council American Society of Anesthesiologists	1978-1981
14.	Education Committee Texas Society of Anesthesiologists	1978-1990
15.	Chairman, Scientific Papers, Annual Meeting Committee American Society of Anesthesiologists	1979
16.	Ad Hoc Committee for Review of Essentials for Anesthesia Assistants	1979-1981

	Program American Society of Anesthesiologists	
17.	Vice Chairman, Annual Meeting Committee American Society of Anesthesiologists	1980
18.	Secretary, Joint Committee on Critical Care Medicine	1981
19.	Chairman, Annual Meeting Committee American Society of Anesthesiologists	1981
20.	Health Care Financing Administration Ad Hoc Committee, American Society of Anesthesiologists	1981-1984
21.	Chairman, Joint Committee on Critical Care Medicine	1982-1984
22.	In-Training Council American Society of Anesthesiologists	1983-1986
23.	Vice President, Committee on Scientific Affairs American Society of Anesthesiologists	1983-1986
24.	Executive Committee American Board of Medical Specialties	1984-1986 1994-
25.	Chairman, Committee for Critical Care Medicine Exam, American Board of Anesthesiology	1984-1987
26.	Oversight Committee for Annual Meeting American Society of Anesthesiologists	1985-1986
27.	Accreditation Council for Graduate Medical Education	1987-1993

28.	Voting Representative for The American Board of Anesthesiology to the American Board of Medical Specialties	1987-present
29.	American Society of Anesthesiologists Representative to American Medical Association Partnership on Practice Parameters	1989-present
30.	Anesthesia Patient Safety Foundation Board of Directors	1990-present
31.	Chairman, Committee on Practice Parameters American Society of Anesthesiologists	1990-present
32.	University Hospital Consortium Board of Directors	1990-present
33.	Member History Committee Texas Society of Anesthesiologists	1993-present
34.	University Hospital Consortium Executive Committee	1993-1995
35.	Member, Council for Medical Affairs American Medical Association	1994
36.	Chairman, Appeals Council American Board of Anesthesiology	1994
37.	University Hospital Consortium Chairman, Group Practice Task Force	1994
38.	Member, Outstanding Community Service Award Association of American Medical Colleges	1995
39.	Liason Council for Specialty Boards American Board of Medical Specialties	1995

UTMB

1.	Chairman, ICU Advisory Committee	1978-1990
2.	Search Committee for Selection of Chairman Department of Pharmacology	1978-1981
3.	President, Medical Service Research and Development Plan Board	1978-1980
4.	Housestaff Committee	1979-1981
5.	Search Committee for Selection of Director Shrine Burns Institute	1979-1981
6.	Chairman, Medical Records and Review Committee	1979-1981
7.	Chairperson, OR Efficiency/Utilization Committee	1984-1990
8.	Group Practice Plan	1984-1990
9.	Chairman, Search Committee for Selection of Chairman, Department of OB/Gyn	1987-1988
10.	Executive Committee, Medical Service Research and Development Plan	1987-present
11.	Member, Administrative Council	1988-present
12.	Chairman, Medical Service Research and Development Plan Board	1988-1990
13.	Steering Committee for 1991-97 UTMB Strategic Plan	1988-1990
14.	Member, University of Texas Provider Panel	1988-1990

15. Chairman, Advisory Committee for Physician Practice Plan Expenditures, UT-System — 1989-1990

16. Member, Advisory Committee for the University of Texas System Professional Medical Liability Self-Insurance Plan — 1989-present

17. Member, Committee on Peer Review and Sanctions The University of Texas System — 1989

18. Chairman, Professional Liability Review Committee — 1990-present

19. Chairman, Disaster Preparedness Committee — 1990-present

20. Member, Claims Review Committee The University of Texas System — 1990-present

21. Chairman, Managed Health Care Advisory Committee to the Texas Department of Criminal Justice — 1993-present

22. Member, MSRDP/PRS Committee The University of Texas System — 1993

23. Member, Committee on Managed Care The University of Texas System — 1993

24. Member, LBB Health Care Reform Project The State of Texas — 1994

25. Chairman, Search Committee for the Selection of Vice President for Academic Affairs and Dean of Medicine — 1994

26. Member, Committee on MSRDP Fringe Benefits The University of Texas System — 1995

27.	Member, Employee Health Insurance Provider Advisory Panel The University of Texas System	1995
28.	Vice Chairman, Governance Committee	1995-present
29.	Chairman, St. Mary's Utilization Task Force Committee The University of Texas Medical Branch	1996
30.	Member, William Temple Foundation Board Houston Diocesan Center	1997-Present

Departmental:

1.	Executive Committee	1986-1990
2.	Resident Selection Committee	1977-1990

Other:

1.	Staff Executive Committee Ochsner Foundation Hospital New Orleans, Louisiana	1968-1972
2.	Dean's V.A. Committee University of Mississippi Medical Center Jackson, Mississippi	1972-1977
3.	Executive Committee University of Mississippi Medical Center Jackson, Mississippi	1972-1977
4.	Chairman, Search Committee for Selection of Chairman Department of Psychiatry	1974

University of Mississippi Medical Center
Jackson, Mississippi

5. Chairman, Ad Hoc Committee on Continuing Education
Mississippi Society of Anesthesiology — 1974

6. Chairman, Judicial Committee
Mississippi Society of Anesthesiology — 1974-1975

7. Faculty Senate
University of Mississippi Medical Center
1974-Member
1975-President Elect
1976-President — 1974-1976

8. Promotions Committee
University of Mississippi Medical Center
Jackson, Mississippi — 1975-1977

9. Joint Conference Committee
University of Mississippi Medical Center
Jackson, Mississippi — 1975-1977

10. Consultant, Special Committee on Health System Reform
Texas Medical Association — 1993

11. Member, Ad Hoc Committee on Town Gown Issues
Texas Medical Association — 1994

MEMBERSHIP IN SCIENTIFIC SOCIETIES:

1. *Academy of Anesthesiology* (Elected)
Member — 1976-1986

2. *American Association of Inhalation Therapists*
Louisiana Chapter
Medical Director — 1972

3. *American Board of Anesthesiology*

Associate Examiner	1970-1975
Director	1975-1987
Vice President	1985-1986
President	1986-1987
Senior Examiner	1987-present

4. *American Board of Medical Specialties*

Member	1978-present
American Board of Anesthesiologists	
Voting Representative	1987
Vice President	1994
President-Elect	1995
President	1996-present

5. *American College of Anesthesiology*

Examiner	1972-1974
Board of Governors	1974-1975
Secretary	1975-1976

6. *American Council of Graduate Medical Education*

Member	1987-1993

7. *American Medical Association*

Member	1982-present
Alternate Delegate ASA	1992-1994
Voting Delegate ASA	1994-present

8. *American Registry of Respiratory Therapists*

Examiner	1970-1975

9. *American Society of Anesthesiologists* (Elected)

Member	1970-1990
Life Member	1990
Vice-President, Scientific Affairs	1983-1986

	First Vice President	1986-1987
	President-Elect	1987-1988
	President	1988-1989
	Immediate Past President	1989-1990
10.	*Association of University Anesthesiologists*	
	Member	1975-present
11.	*Faculty of Nurse Anesthesia Schools*	
	President	1975-1977
12.	*International Anesthesia Research Society*	
	Member	1972-1993
13.	*Louisiana Society of Anesthesiology*	
	Vice President	1968-1977
	President Elect	1969-1970
	President	1971-1972
14.	*Mississippi Society of Anesthesiology*	
	Member	1974-1975
15.	*Society of Academic Anesthesia Chairman*	
	Member	1975-1990
	President	1979-1980
16.	*Society of Cardiovascular Anesthesiologists*	
	Member	1979-1993
17.	*Society of Critical Care Medicine* (elected)	
	Member	1975-1993
18.	*Southern Medical Association*	
	Secretary, Section on Anesthesiology	1972
	Chairman Elect, Section on	

Anesthesiology	1973
Chairman, Section on Anesthesiology	1974

19. *Southern Society of Anesthesiology*

Vice President	1970-1971
President Elect	1971-1972
President	1972-1973

20. *Texas Medical Association*

Member	1982-present
Consultant	1993

21. *Texas Society of Anesthesiologists*

Member	1977-1990
Life Member	1990
Alternate Delegate, T.S.A.	1983-1986
Board of Directors, Ex Officio	1986-present

BOARD CERTIFICATION:

National Board of Medical Examiners (#42334)	1960
American Board of Anesthesiology (#3577)	1965
American College of Anesthesiology	1966
ABA – Critical Care Medicine (#1 Certificate)	1986
ABA – Continued Demonstration of Qualifications (#25)	1993

LICENSURE INFORMATION:

Texas E9515

HONORS:

1. Leone Award for Administrative Excellence 1984

The University of Texas
Medical Branch
Galveston, Texas

2. Bernard H. Eliesberg Lecturer — 1984
Mt. Sinai Hospital
New York, New York

3. Rebecca Terry White Chair in Anesthesiology — 1985-1991
The University of
Texas Medical Branch
Galveston, Texas

4. Establishment of James F. Arens Chair in Anesthesiology — 1986
The University of
Texas Medical Branch
Galveston, Texas

5. First Speaker at the Jerry Nudell Memorial Lecture — 1990
Cedars Sinai Medical Center
Los Angeles, California

6. Creighton University School of Medicine — 1991
Alumni Merit Award
Omaha, Nebraska

7. Establishment of The James F. Arens and Ann G. Arens Endowed Fund — 1995
The University of
Texas Medical Branch
Galveston, Texas

8. Forrest E. Leffingwell Memorial Lecture — 1996
California Society of Anesthesiologists
San Francisco, California

9. T. H. Seldon Lecture — 1997
International Anesthesia
Research Society
San Francisco, California

ADDITIONAL INFORMATION:

1. American Society of
Anesthesiologists — 1984
Representative to CMSS
Regarding DRG's

2. American Society of
Anesthesiologists Representative — 1986-1990
Health Care Financing
Administration – Harvard
Relative Value Study (Hsaio Study)

Exhibits:

1. Intermittent Cuff Inflation for Long-Term Ventilation.

   A. American Society of Anesthesiology National Meeting, San Francisco, California, October 1969.

   B. New York Society of Anesthesia, New York, New York, December 1969.

   C. American Medical Association National Meeting, Chicago, Illinois, June 1970. (Certification of Merit-Section on Anesthesiology)

   D. Midwest Anesthesiology Conference, Chicago, Illinois, May 1971.

   E. International Anesthesia Research Society National Meeting, Bal Harbor, Florida, March 1971.

2. Post-Traumatic Respiratory Insufficiency.

   A. American Society of Anesthesiology National meeting, New York, New York, November 1970. (First Place Scientific Exhibits)

   B. American College of Surgeons National Meeting, Atlantic, New Jersey, October 1971.

   C. International Anesthesia Research Society National Meeting, Las Vegas, Nevada, March 1972.

   D. Louisiana State Medical Society, New Orleans, Louisiana, May 1972. (First Place Scientific Exhibit)

3. Morphine Anesthesia for Coronary Artery Disease.

   A. American Society of Anesthesiology National Meeting, Atlanta, Georgia, October 1971.

   B. American College of Cardiology National Meeting, Chicago, Illinois, March 1972.

   C. American Medical Association National Meeting, San Francisco, California, June 1972.

   D. Association of American Medical Clinics, Atlanta, Georgia, September 1972.

   E. American College of Surgeons National Meeting, San Francisco, California, October 1972.

BIBLIOGRAPHY:

Articles in Peer-Reviewed Journals

1. *Arens, J.F.* Post-anesthetic vomiting. Am. J. Surg. 103:2-5; 1962.

2. *Arens, J.F.* Use of antagonists in drug-induced coma. JAMA 1979:752-758; 1962.

3. *Arens, J.F.* Clinical effectiveness and usefulness of topical anesthetics. Postgrad. Med. 33:269-276; 1963.

4. *Arens, J.F.* Use of angiotensin as an adjunctive agent to correct hypotensive states during anesthesia. Anesth. Analg. 42:536; 1963.

5. *Arens, J.F.* Comparative potency and effectiveness of topical anesthetics in man. Clin. Pharmacol. Ther. 5:49-62; 1964.

6. *Arens, J.F.* Cardiovascular effects of muscle relaxants. J. Am. Assoc. Nurse Anesth. 36(2):120-122; 1968.

7. *Arens, J.F.* Methoxyflurane and epinephrine administered simultaneously. Anesth. Analg. 47:530-534; 1968.

8. *Arens, J.F.* Volume limited intermittent cuff inflation for long-term respiratory assistance. J. Thorac. Cardiovas. Surg. 58:837-853; 1969.

9. *Arens, J.F.* Effect of various drugs on the course of anesthesia. J. Louisiana State Med. Soc. 122:380-382; 1970.

10. *Arens, J.F.* Carrera, A.E. Methemoglobin levels following peridural anesthesia with prilocaine for vaginal deliveries. Anesth. Analg. 92:219-222; 1970.

11. *Arens, J.F.* Epidural and caudal anesthesia for complicated obstetrics. South. Med. J. 63:44-48; 1970.

12. *Arens, J.F.* Sedation for patients on long-term ventilatory care. Inhal. Therap. 15:50-53; 1970.

13. *Arens, J.F.* Recovery Room. Topics 49: June, 1971.

14. *Arens, J.F.* Leonard, G.L. Danger of overwarming blood by microwave. JAMA 218:1045; 1971.

15. *Arens, J.F.* A hazard in the use of an Ayre's T-Piece. Anesth. Analg. 50:943-946; 1971.

16. *Arens, J.F.* Shook lung. South. Med. J. 65:206-208; 1972.

17. *Arens, J.F.* McKinnon, W.M.P. Malignant hyperpyrexia during anesthesia. JAMA 215:919-922; 1971.

18. Weber, D.R.; Benbow, B.P.; *Arens, J.F.* Pulmonary edema as a complication of increased intracranial pressure. South. Med. J. 65;1352-1355; 1972.

19. Scott, M.L.; Webre, D.R.; *Arens, J.F.*; Ochsner, J.L. Clinical application of a flow-directed balloon-tipped cardiac catheter. Am. Surg. 38:690-696, 1972.

20. *Arens, J.F.*; Banbow B.J.; Ochsner, J.L.; Theard, R.R. Morphine anesthesia for aorto-coronary bypass procedures. Anesth. Analg. 51:901-909; 1972.

21. Webre, D.R.; *Arens, J.F.* Use of cephalic and basilic veins for introduction of central venous catheters. Anesth. 38:389-392; 1973.

22. Scott, M.L.; *Arens, J.F.*; Ochsner, J.L. Fractured sternum with flail chest and post-traumatic pulmonary insufficiency syndrome. Ann. Thorac. Surg. 15:386-393; 1973.

23. *Arens, J.F.*; Ethrane. J. Am. Assoc. Nurse Anesth. 42:141-145; 1974.

24. *Arens, J.F.*; LeJeune, F.E.; Webre, D.R. Maxillary sinusitis: A complication of nesotracheal intubations. Anesth. 40:415-416; 1974.

25. Barson, P.; *Arens, J.F.* Ketamine as an induction anesthetic for poor-risk patients. South. Med. J. 67:1398-1402; 1974.

26. Peuler, M.; *Arens, J.F.*; Glass, D.D. Ketamine and intraocular pressure. Anesth. 43:575-581; 1975.

27. *Arens, J.F.* Extracorporeal circulation: Practice considerations in the use of the heart pump. Am. Soc. Anesth. Refresher Course Publications; 1976.

28. Glass, D.D.; Tonnesen, A.S.; Gabel, J.C.; *Arens, J.F.* Therapy of unilateral pulmonary insufficiency with a double-lumen endotracheal tube. Crit. Care med. 4:323-326; 1976.

29. Malone, R.A.; McLeavey, C.A.; *Arens, J.F.* Plasma osmotic changes during major abdominal surgery. South. Med. J. 1443, 1446; 1977.

30. Gabel, J.C.; Drake, R.E.; *Arens, J.F.*; Taylor, A.E. Unchanged pulmonary capillary filtration coefficients after Escherichia Coli endotoxin infusion. J. Surg. Res. 25(2):97-104; 1978.

31. Tonnesen, A.S.; *Arens, J.F.*; Ellis, E.G.; Glass, D.D. Duration of laryngeal symptoms following intubation for mechanical ventilation. Anes. Rev. 5(11):28-31; 1978.

32. *Arens, J.F.* What's New in Anesthesiology? Texas Med.; 1979.

33. Kurusz, M.; Christmas, B.S.; *Arens, J.F.*; Tyson, K.R.T. Sodium nitroprusside as an adjunct to pediatric perfusion. J. Extracorporeal Tech. 11:189-194; 1979.

34. Polacheck, J.; Strong, R.; *Arens, J.F.*; et al. Phasic vagal influence on inspiratory motor output in anesthetized human subjects. J. Appl. Physiol. 49(4):609-619; 1980.

35. Grenvik, A.; Leonard, J.J.; *Arens, J.F.*; Carey, L.C.; Disney, F.A. Critical care medicine certification as a

multidisciplinary subspecialty. Crit. Care Med. 9(2):117-125; 1981.

36. Tonnesen, A.S.; Vereen, L.; *Arens, J.F.* Endotracheal tube cuff residual volume and lateral wall pressure in a model trachea. Anesth. 55:680-683; 1981.

37. Priano, L.L.; Marrone, B.; Huber, P.; Arnold, J.A.; *Arens, J.F.* An unusual catheter complication with continuous epidural anesthesia. Anesth. Analg. 62(4):447-449; 1983.

38. Flewellen, E.H.; Nelson, T.E.; Jones, W.P.; *Arens, J.F.*; Wagoner, D.L. Dantrolene dose response in awake man: Implications for management of malignant hyperthermia. Anesth. 59:275-280; 1983.

39. Kurusz, M.; Cooper, J.R.; Grant, J.A.; *Arens, J.F.*; Conti, V.R. Protamine reactions in insulin-dependent diabetics following cardiopulmonary bypass. Proceedings of the American Academy of Cardiovascular Perfusion 5:153-157; 1984.

40. Johnston, R.V.; Nicholas, D.A.; Lawson, N.W.; Wallfisch, H.K.; *Arens, J.F.* The use of rectal clonidine in the perioperative period. Anesthesiology 64:288-290; 1986.

41. L'Hommedieu, C.S.; *Arens, J.F.* The use of ketamine for the emergency intubation of patients with status asthmatious. Ann. Emerg. Med. 16:568-571; 1987.

42. Samra, S.K.; Turk, P.; *Arens, J.F.* Effect of hypocapnia on local cerebral glucose utilization in rats. Anesthesiology 70:523-526, 1989.

43. Andrews, J.J.; Johnston, Jr., R.V.; Bee, D.; *Arens, J.F.* Photodeactivation of ethyl violet; a potential hazard of sodasorb. Anesthesiology 72:0059-0064, 1990.

44. Dehring, D.J.; *Arens, J.F.* Pulmonary thromboembolism: disease recognition and patient management. Anesthesiology 73:146-164, 1990.

45. *Arens, J.F.,* The American Society of Anesthesiologists and You. Seminars in Anesthesia. 10,#3:145-152, 1990.

46. Kurusz, M.; Andrews, J.; *Arens, J.F.*; Conti, Vincent R. Monitoring Oxygen Concentration Prevents Potential Adverse Patient Outcome Caused by a Scavenging Malfunction: Case Report. American Academy of Cardiovascular Perfusion, Volume 12, 162-165 February 1991.

47. *Arens, J.F.*, Substance Abuse: One anesthesiologist's perspective. Bulletin American College of Surgeons. 78:10-15; November 1993

48. *Arens, J.F.*, Outdated Anesthesia Equipment, Journal of Clinical Monitoring, 12:39-41, 1996

49. *Arens, J.F.*, Roizen, M.F., Pros/Con of Practice Parameters. Journal of Cardiothoracic and Vascular Anesthesia, Volume 10, Number 4 June 1996 pp538-39

Publications – Other

1. *Arens, J.F.* General principles of anesthesia. In: *Rhodes Textbook of Surgery*, Hardy, J.D. (Editor), J.B. Lippincott, Philadelphia, Pennsylvania, 1976.

2. *Arens, J.F.* Major changes on horizon for nation's health care system, Galveston Daily News, December 15, 1991.

3. *Arens, J.F.,* Health care system transformation – 1995 in *Clinical Anesthesia Updates*, Barash, Cullen

& Stoelting (Editors), Lippencott-Raven, Philadelphia, Pennsylvania, Volume 6, Number 3.

4. *Arens, J.F.,* Practice Parameters for Anesthesiology. In Health Economics and Practice Management in Anesthesia, *International Anesthesia Clinics – Fall 1995*, Macario and Lang (Editors), Little, Brown and Company, Boston, Massachusetts, Volume 33, Number 4 pp103-117.

5. *Arens, J.F.,* Pulmonary Atresia. *Essence of Anesthesia Practice*, Roizen and Fleisher (Editors), W. B. Saunders, Orlando, August 1996 p 265

6. Dehring, D.J., Coffin, S.A., *Arens, J.F.* Care of the patient with thromboembolic disorders. In *Critical Care Medicine – Perioperative Management*, Murray, Coursin, Pearl and Prough (Editors), Lippincott – Raven Press, New York, New York Chapter 48 pp 575-587

Abstracts:

1. Gabel, J.C.; Guidry, O.F.; Meredith, S.R.; Tonnesen, A.S.; *Arens, J.F.*: Microcirculation in oxygen tension measurements. American College of Chest Physicians National Meeting, Atlanta, Georgia, October, 1976.

2. Tonnesen, A.S.; Cooper, J.R.; Gabel, J.C.; *Arens, J.F.*: Relationship between therapeutic intervention scoring system and mortality. Amerian Society of Anesthesiologists Annual Meeting, San Francisco, California, October, 1976.

3. Gabel, J.C.; Malone, R.A.; McLeavey, C.A.; *Arens, J.F.*: The lung safety factor and major abdominal surgery. 70th Annual Scientific Assembly of the Southern Medical Association, November, 1976.

4. Tonnesen, A.S.; Gabel, J.C.; Guidry, O.F.; Drake, R.E.; *Arens, J.F.*; Lack of effect of 100% O_2 breathing on shunt. American Society of Anesthesiologists Annual Meeting, New Orleans, Louisiana, October, 1977.

5. Tonnesen, A.S.; Glass, D.D.; Ellis, E.G.; *Arens, J.F.*; Symptoms following prolonged intubation. American Society of Anesthesiologists Annual Meeting, New Orleans, Louisiana, October, 1977.

6. Polacheck, J.W.; *Arens, J.F.*: Influence of phasic lung volume on inspiratory duration in anesthetized man. 1979.

7. Gabel, J.C.; Drake, R.E.; *Arens, J.F.*: Oxygenation as an indicator of lung fluid accumulation. American Society of Anesthesiologists Annual Meeting, Anesthesiology 51 (3): 5156; 1979.

8. *Arens, J.F.*: Pharmacology of extracorporeal circulation. American Society of Anesthesiologists Refresher Course Outline, 1980.

9. *Arens, J.F.*: Principles of extracorporeal circulation. American Society of Anesthesiology Refresher Course Outline, 1982.

10. Grant, J.A.; *Arens, J.F.*; Cooper, J.R.; Buhner, D.; Farnam, J.; Conti, V.; Guernsey, B.: Anaphylactic reactions toprotamine in insulin-dependent diabetics after cardiopulmonary bypass. Clinical Research 31(2):457A; 1983.

11. *Arens, J.F.:* Anesthesia for congenital heart disease. American Society of Anesthesiologists Refresher Course outline, 1983.

12. *Arens, J.F.:* Management of cardiopulmonary bypass. American Society of Anesthesiologists Refresher Course Outline, 1983.

13. *Arens, J.F.*: Anesthesia for adult cardiac surgery. American Society of Anesthesiologists Refresher Course Outline, 1985.

14. Dehring, D.J.; Traber, D.L.; Fader, R.; Brown, M.; Traber, L.D.; *Arens, J.F.*: Hyperdyanmic sepsis and pulmonary clearance of bacteria following intravenous Ps. aeruginosa in awake sheep. Anesthesiology 63:A121, 1985.

15. Kurusz, M.; Conti, V.; *Arens, J.F.*: Survey of pump accidents. American Society of Anesthesiologists Annual Meeting, October, 1986.

16. Kurusz, M.; Conti, V.R.; *Arens, J.F.*; Brown, J.P.; Faulkner, S.C.; Manning, J.V.: Perfusion accident survey. Proceedings of American Academy of Cardiovascular Perfusion 7:57; 1986.

17. Neal, M.B.; Wallfisch, H.K.; *Arens, J.F.*: Comparison of complications from right internal jugular and left subclavian vein cannulation in a training program. American Society of Anesthesiologists Annual Meeting, Anesthesiology 67(3A):A222; 1987.

18. Samra, S.K.; Eisenberg, H.M.; *Arens, J.F.*: Effect of nitrous oxide on global and regional cerebral blood flow in humans. American Society of Anesthesiologists Meeting, San Francisco, CA – 1988. Anesthesiology 69:A-586; 1988.

19. Samra, S.K.; Turk, P.; *Arens, J.F.*: Effect of hypocapnia on regional cerebral glucose utilization. American Society of Anesthesiology Meeting, San Francisco, CA – 1988. Anesthesiology 69:A-428; 1988.

20. Dehring, D.J.; Coffey, J.A.; Doty, S.; Traber, L.D.; Traber, D.L.; *Arens, J.F.*: Tolerance to bacterial bolus induced by chronic low dose bacteremia in sheep. Anesthesiology 69:A206, 1988.

21. Dehring, D.J., Beerthuizen, G.; Traber, D.; Traber, L.; *Arens, J.F.*: Hyperdynamic circulation with antibiotic killed Gram$^+$ or Gram$^-$ bacteria. Anesthesiology 71:A178, 1989.

22. *Arens, J.F.*: Extracorporeal Circulation: Past, Present, and Future. American Society of Anethesiology Refresher Course, San Antonio, Texas 1993.

23. *Arens, J.F.*: RBRVS: One Year Later. American Society of Anesthesiology Regional Refresher Course, San Antonio, Texas, 1993.

24. *Arens, J.F.*: Negotiating with Managed Care Contract Holders. American Society of Anesthesiologists Refresher Course Lecture, San Francisco, California, 1994

25. *Arens, J.F.*: Negotiating with Managed Care Contract Holders. American Society of Anesthesiologists Refresher Course Lecture, Atlanta, Georgia, 1995

26. *Arens, J.F.*: Negotiating with Managed Care Contract Holders. American Society of Anesthesiologists Refresher Course Lecture, Washington, D.C., April 1996

27. *Arens, J.F.*: Managed Care. American Society of Anesthesiologists Refresher Course Lecture, New Orleans, Louisiana, October 1996

REPORT OF BERTRAM W. COFFER, M.D.

ANESTHESIA PRACTICE DESCRIPTION

I am Bertram W. Coffer, M.D., an anesthesiologist in a group practice (now known as Critical Health Systems of North Carolina), in Raleigh, North Carolina since 1975. Currently, I am Chairman of the Board of Critical Health Systems of North Carolina and Chief of Anesthesia at Rex Hospital in Raleigh, North Carolina. I have practiced in the anesthesia care team mode since 1975. In early 1996, Raleigh Anesthesia Associates, Inc., which was our original practice, merged with Wake Anesthesia Associates to form Critical Health Systems of North Carolina. Critical Health Systems of North Carolina now employs 30 anesthesiologists and approximately 100 certified registered nurse anesthetists (CRNAs) with an administrative staff of 20-25 people including personnel responsible for billing, which we do in-house. I was President of Raleigh Anesthesia Associates, Inc. for 5 years, and am now Chairman of the Board of Critical Health Systems of North Carolina. I have been Chief of Anesthesia at Rex Hospital for the past 21 years. Other hospital related positions include memberships in the following committees: Operating Room Committee, Executive Committee, HIS Steering Committee, Chairman, Same Day Surgery Committee, Medical Practice Committee, Cardiovascular Committee, all at Rex Hospital.

Additionally, I have been Medical Director of the Same Day Surgery Center at Rex Hospital since 1986 to the present. I was on the Executive Committee of Raleigh Anesthesia Associates, Inc. from 1978 until 1996, and was President from 1992 until 1996. As my CV indicates, I have held various leadership roles in the ASA and other

medical societies. In my leadership roles, I have become knowledgeable about billing matters, including Medicare billing requirements

PROFESSIONAL ACTIVITIES

During the course of my 20 years in private practice, I have been heavily involved in the American Society of Anesthesiologists (ASA) in many ways. I was a member of the House of Delegates from 1984 until 1990 and served as president of the North Carolina Society of Anesthesiologists from 1982-83. Since 1990 I have been a member of the Board of Directors of the ASA as well as serving on numerous committees. During this tenure, I have been Chairman of the Anesthesia Care Team Committee and Chairman of the Committee on Governmental Affairs for the ASA. I also chaired a committee known as the ad hoc Committee on Medical Direction Reimbursement from 1991-94. In 1992, I was a member of the Center for Health Economics Research panel for medical direction reimbursement. A review of my curriculum vitae will show that I have been involved in these and many other activities over the last two decades. Due to the extent of my involvement, I have become quite familiar with anesthesia practices in North Carolina as well as all parts of the country. In the positions I have held, I have also become quite familiar with health care regulation and practice management issues throughout the country.

MEDICARE REGULATORY BACKGROUND OF DR. COFFER

My experience with Medicare and Medicare regulations began in the early 1980s when I was an officer in the

North Carolina Society of Anesthesiologists. My exposure became very intense in late 1982 and 1983 when I became aware that the Health Care Financing Administration (HCFA) was putting forth proposed and final regulations relating to anesthesia billing. At the time, I was President of the North Carolina Society of Anesthesiologists and became intensely involved in discussion with the American Society of Anesthesiologists, legislators, and HCFA to modify these regulations. In the course of these discussions, the issue of requirements of an anesthesiologist for medical direction arose. I was one of the early advocates that there were very specific things that anesthesiologists should do in order to qualify for Medicare reimbursement. Over the course of the next 15 years, I continued to consult with Congressional offices and professional individuals regarding HCFA regulations and their interpretation. It was my involvement and knowledge of these issues that led me to become intensely involved with my own professional organizations (the American Society of Anesthesiologists and the North Carolina Medical Society) throughout this period of time. This activity on occasion led to face to face discussions with legislators and HCFA employees on these issues.

LIST OF SOURCES RELIED UPON AND/OR CONSIDERED IN FORMING OPINIONS

- Complaint in Antitrust case and Second Amended and Third Amended Complaint in Qui Tam case
- Medicare regulations
- 7/15/93 HCFA Memorandum (C. Booth)
- Materials from North Carolina carrier

- Materials from Travelers to Minnesota anesthesiologists

- Materials from Blue Cross to Minnesota anesthesiologists

BACKGROUND AND QUALIFICATIONS

See attached Curriculum Vitae

PUBLICATIONS

None

PRIOR TESTIMONY

I was an expert witness and gave a deposition involving the death of a patient after an anesthesiologist performed a subclavian vena puncture for CVP placement. This involved a patient in eastern North Carolina and the deposition was given in the office of Robert Clay in 1996. I have offered no other court testimony or deposition in the past four years.

MEDICARE UPDATES FOR THE PRACTICING ANESTHESIOLOGIST

In my opinion and based on my experience and knowledge, the average anesthesiologist in private practice obtains information about Medicare regulation and policies from three sources: (1) his or her Medicare carrier, (2) ASA sources and mailings, and (3) the professional billing group that files claims for the anesthesiologist or his or her group. It is my opinion that most anesthesiologists

rely on their carriers' interpretations and opinions as to how they should bill for Medicare. Most anesthesiologists would regard their carriers' interpretation as the final word on Medicare regulations and policies.

"OPERATING ROOM" VERSUS "OPERATING SUITE"

In my opinion and based upon my experience and knowledge, the term "operating room" refers to a single individual operating room where a single patient's surgical procedure is performed. The term "operating suite" refers to a complex of multiple operating rooms and associated hallways, offices and other rooms in the same location within a hospital or other facility.

ANESTHESIOLOGISTS' RESPONSIBILITY/OPERATING ROOM/ANESTHESIA CARE TEAM

It is my opinion that the Medicare regulations require an anesthesiologist generally to remain in the operating suite and immediately available to any case that he or she is directing. I do not believe that the regulations require the anesthesiologist to remain in the operating room because another qualified anesthesia provider (usually a CRNA) is in the operating room with the patient. The basis for my opinions comes from numerous Medicare directives that have been provided by the carrier. My opinions also are derived from a Medicare Bulletin that was published in October of 1993 from the carrier regarding the use of "AA modifier." It is my opinion that the anesthesiologist's responsibility for remaining in the suite is no different whether he or she is directing one, two, three or four cases.

Anesthesiologists working in the anesthesia care team mode work most often with CRNAs. Anesthesiologists and CRNAs undergo substantially different training. The anesthesiologist's medical training is much longer and more in depth than the CRNA's nursing training .

MEDICARE REIMBURSEMENT REQUIREMENTS FOR ANESTHESIOLOGISTS

There are seven specific requirements that an anesthesiologist must meet in order to qualify for Medicare reimbursement in an anesthesia care team practice:

1. Perform a preanesthetic examination and evaluation;
2. Prescribe the anesthesia plan;
3. Participate in most demanding portions (including induction and emergence) of the procedure;
4. Ensure residents/nurse anesthetists are qualified;
5. Frequently monitor course of anesthesia;
6. Remain physically present and available for immediate diagnosis and emergencies; and
7. Provide indicated post-anesthesia care.

As noted above, the anesthesiologist is required to participate in the most demanding portions of the procedure, including induction and emergence from the procedure. The anesthesiologist monitors the course of the procedure, particularly procedures lasting several hours. The anesthesiologist is required to remain immediately available for any emergencies. Under the Medicare regulations, it is

permissible for an anesthesiologist in a group practice to transfer responsibility for a case to another anesthesiologist in his or her group, so long as all seven of the above-criteria are performed. Anesthesiologists must also provide post-operative care. It is the anesthesiologist who makes the final determination that the patient is stable and ready to leave the post-anesthesia care unit. In my opinion and based on my knowledge and experience, participating in emergence means that the anesthesiologist must be available and aware of the progress of the patient emerging from anesthesia. Furthermore, it is my opinion that emergence is not a specific moment in time, but rather a process that involves the elimination of the anesthetic from the patient's body as the patient gradually recovers intellectual functioning. This process usually (but not always) begins in the operating room and extends hours or days thereafter. With regard to regional anesthesia, emergence is a process that involves the elimination of the anesthetic from the patient's body but it begins as soon as the block hits its peak. The Medicare requirements regarding participation in emergence were not meant to imply that the anesthesiologist had to return to the operating room at the end of every single case. They do imply that the anesthesiologist needs to be involved in the emergence of the patient whether it be in the operating room, the recovery room, or both, depending on the circumstances.

COMPENSATION FOR EXPERT TESTIMONY/MINNESOTA CASE

I expect to receive airfare and hotel accommodations should I be asked to come to Minnesota for any trial or deposition. I do not expect to receive any compensation for testimony or deposition unless it directly takes time away from practice. If I have to testify and lose time from practice, I would expect my compensation would be no

more than $200 per hour. It should be noted that this compensation will not be received by me personally, but will revert to my practice corporation.

/s/ Bertram W. Coffer, M.D.
Bertram W. Coffer, M.D.

Dated: *12/5/92*

CURRICULUM VITAE
BERTRAM WATTS COFFER, M.D.

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FAX (919) 783-9441	FAX (919) 846-1094

BORN:	May 24, 1941 Sanford, North Carolina
MARRIED:	Jeanne Elizabeth Gardner, R.N.
EDUCATION:	
1964 B.Sc.	North Carolina State University Raleigh, NC
1969 M.D.	University of North Carolina Chapel Hill, NC
1969-1971	Residency, Department of Surgery Duke University
1973-1975	Residency Department of Anesthesia North Carolina Memorial Hospital

MILITARY

1971-1973	U.S. Navy, Lt. Commander

CERTIFICATIONS:

1975	American College of Anesthesiologists
1976	American Board of Anesthesiology

MEDICAL LICENSES North Carolina, Georgia, Florida

AWARDS AND HONORS

1977-95	AMA Physician's Recognition Award for Continuing Medical Education
1992	Phi Kappa Phi, NC State University

PROFESSIONAL SOCIETY MEMBERSHIPS:

American Society of Anesthesiologists
American Medical Association
International Anesthesia Research Society
North Carolina Medical Society
Anesthesia Care Team Society
Wake County Medical Society
Raleigh Academy of Medicine
Royster Medical Society
North Carolina Society of Anesthesiologists

PRIVATE PRACTICE: RALEIGH ANESTHESIA ASSOCIATES, INC.

1975-91	Chief Executive Officer
1991-	President
1975-	Rex Hospital
1978-	Raleigh Community Hospital
1985-89	Blue Ridge Ambulatory Surgery Center

ACADEMIC POSITIONS:

1975-86	Assistant Professor of Anesthesiology University of North Carolina School of Medicine, Chapel Hill, NC

ELECTED PROFESSIONAL OFFICES:

American Society of Anesthesiologists:

1984-90	Member, House of Delegates
1986-89	Alternate Director, #27
1989-98	Director, District 27
1991-96	Board of Directors, ASA PAC
1991-94	Vice Chairman, Southern Caucus

Other:

1980-93	Executive Committee, NCSA
1980-82	Secretary-Treasurer, NCSA
1982-83	President, NCSA
1982	Secretary-Treasurer, Royster Medical Society
1982-90	Delegate, NC Medical Society
1983	Vice President, Wake County Medical Society
1983	President, Royster Medical Society
1985	President-Elect, Wake County Medical Society
1986	President, Wake County Medical Society
1988-96	Board of Directors, NC Medical Society Foundation
1989-90	Member, BCBS Anesthesiology Committee
1991	Alternate Delegate NC Medical Society
1992-93	First Vice President, NC Medical Society
1989-96	V. President, NC Medical Society Foundation
1986-96	Board of Directors, Carolina Doctors Care

1986-96	Executive Committee, Carolina Doctors Care
1985-96	Board of Directors, Health Care Savings
	MED PAC, NC Medical Society

APPOINTED POSITIONS:

American Society of Anesthesiologists:

1984-96	Member, Governmental Affairs Committee
1995-96	Chairman, Governmental Affairs Committee
1984, 86	Member, Reference Committee
1987, 89	Member, Reference Committee
1988-93	Member, Manpower Committee
1990, 92	Member, Reference Committee
1990-93	Member, Committee on Finance
1991-94	Chairman, Ad Hoc Committee on Medical Direction Reimbursement
1993-95	Chairman, Anesthesia Care Team Committee
1993-96	Committee on Scientific Affairs
1992	Member, CHER Panel for Medical Direction Reimbursement

Other:

1975-97	Operating Room Committee, Rex Hospital
1978-97	Executive Committee, Rex Hospital
1976-97	Chairman, Department of Anesthesia Rex Hospital
1976-82	Board of Directors, Wake County Blood Plan
1978-84	Consultant, NC Central Prison
1980-88	HIS Steering Committee, Rex Hospital
1983-89	Chairman, Coordinating Council of Medical Specialties, N C Medical Society

1983-89	Executive Council, N C Medical Society
1984-85	Chairman, Section on Anesthesiology, NCMS
1984-85	Member, Committee on Membership, NCMS
1985-86	Medical Director, Respiratory Care, Rex
1986-97	Chairman, Same Day Surgery Committee, Rex
1986-97	Medical Director, Same Day Surgery, Rex
1986	Medical Practice Committee
1986-93	Cardiovascular Committee
1992-93	Executive Committee, NC Medical Society
1984-96	Legislative Committee, NC Medical Society
1989-94	Finance Committee, NC Medical Society
1988-97	Executive Committee, NCMS Foundation
1989	Member, Planning Council, NC Medical Society
1993-94	Chairman Long Range Planning Committee N C Medical Society
1990-91	Chairman, Legislative Committee, Wake County Medical Society
1991-94	Aids Committee, N C Medical Society

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA
FOURTH DIVISION

United States of America,
ex rel Minnesota Association
of Nurse Anesthetists,

Plaintiff,

vs.

Allina Health System Corp.,
et al.,

Defendants.

AFFIDAVIT OF KATHY PARSONS

Court File No.
4-96-734-L JGL

STATE OF MINNESOTA)
) ss.
COUNTY OF STEARNS)

I, Kathy Parsons, being first duly sworn upon oath, depose and states as follows:

1. My title is Director of Managed Care Contracting for the St. Cloud Hospital. I have held this position since 1990. Prior to that time I was a Managed Care Contract Analyst since July 1988.

2. As Director of Managed Care Contracting, I am, and at all times relevant to this action was, responsible for understanding Medicare billing and reimbursement for the St. Cloud Hospital.

3. Prior to 1989, CRNA services provided and billed to Medicare patients were reimbursed on the St. Cloud Hospital Cost Report submitted pursuant to Part A of the Medicare Program. Under Part A, the St. Cloud Hospital determined the cost of providing CRNA services to

Medicare patients, submitted those costs as part of its cost report to the medical intermediary, Blue Cross/Blue Shield of Minnesota ("BCBSM"), and received reimbursement from BCBSM as part of its overall reimbursement from Medicare for all services provided to Medicare patients at St. Cloud Hospital.

4. Beginning in 1989, Congress changed the way in which CRNA services provided to Medicare patients were billed by hospitals. Rather than the pass-through under Medicare Part A as described in Paragraph 3, CRNA services were billed directly to BCBSM under Part B. Because BCBSM had difficulties in transitioning the program from Part A to Part B, BCBSM did not begin reimbursement until after the first quarter of 1989. I had a number of phone calls with representatives of BCBSM during the early part of 1989 as the CRNA reimbursement transition occurred in an effort to comply with program billing requirements.

5. In July or August 1989, representatives from BCBSM, including Linda Mack, met at the St. Cloud Hospital with members of St. Cloud Hospital billing staff, anesthesiologists from Defendant AASC, and St. Cloud Hospital CRNAs. I participated in that meeting. In that meeting we discussed billing issues. We discussed billing for CRNA services by St. Cloud Hospital, including billing for Medicare medical necesity cases. I believe that BCBSM had an understanding of how St. Cloud Hospital billed for anesthesia services provided by St. Cloud Hospital. They did not object to how the Hospital billed for its CRNA services, including Medicare medical necessity cases.

6. Attached hereto as Exhibit A (Deposition Exhibit 1184) is a letter from Linda Mack to me dated August 28, 1989. This letter followed the meeting referred to in Paragraph 5 and a discussion I had with Ms. Mack about billing for CRNA services. I believe Ms. Mack understood how St. Cloud Hospital billed for CRNA services. She made no objection to how St. Cloud Hospital billed CRNA cases.

7. In August 1990, representatives for BCBSM again met with representatives of St. Cloud Hospital regarding the billing of CRNA services, including Mary Stotko from the Hospital billing office. St. Cloud Hospital CRNAs, and me. I recall that Linda Krecklau and one other person attended this meeting as representatives of BCBSM. At the time of that meeting in August 1990, St. Cloud Hospital was still having trouble receiving reimbursement for CRNA services. Attached hereto as Exhibit B (Bates No. SCH006370), is a follow-up correspondence to St. Cloud Hospital from BCBSM dated August 29, 1990, indicating a discussion of medical necessity cases was held (cases in the letter identified as procedure codes 00562, 00210, 00216, 00218, 00220, 00222, 00350, 00770, and 00880). In that meeting and subsequent letter, BCBSM affirmed how we were billing these medical necessity cases and, in fact, reimbursed us for cases which had been improperly denied by it dating back to the inception of Part B billing by CRNAs, January 1989.

8. St. Cloud Hospital used the modifier code "ZF" prior to late 1991 to bill for CRNA services in medical necessity cases, and has used "QX" since 1992. I did not receive any instruction from BCBSM or any other carrier, intermediary, or governmental agency indicating that these

were the incorrect modifiers to use in medical necessity cases.

FURTHER AFFIANT SAITH NOT.

/s/ Kathy Parsons
Kathy Parsons

Dated: July 30, 1998

Subscribed and sworn to before me this 30th day of July, 1998.

/s/ Tracy Hamilton Curran
Notary Public

(LOGO)
TRACY HAMILTON CURRAN
NOTARY PUBLIC –
MINNESOTA
My Comm. Exp. Jan. 31, 2000

MEDICARE

Part S Office – P.O. Box 84357 –St. Paul, Minnesota 55164 – (612) 456-8000

August 28, 1989

Kathy Parsons
St. Cloud Hospital
1406 6th Ave North
St. Cloud, MN 56303

Dear Mr. Parsons:

This is in response to our recent telephone conversation regarding reimbursement of services for both CRNA and anesthesiologist when there is a single case being performed.

According to the Medicare Carriers Manual, Section 5261 G, our instructions from the Health Care Financing Administration (HCFA) are as follows: "Where an anesthesiologist and an anesthetist are both involved in a single anesthesia service, the service is considered personally performed by the anesthesiologist. No separate payment is ordinarily recognized for the anesthetist's service. You may recognize a separate CRNA fee schedule payment only if you receive documentation showing that it is medically necessary for both the anesthesiologist and the anesthetist to be involved."

There may be certain surgical cases that require both the MDA and CRNA, some types of cases would be open heart surgery, craniotomy, spinal fusion, endarterectomy, trauma cases, etc. When a case does require more than one person to perform anesthesia, Medicare will make payment for the CRNA if medical justification is sent and it is determined by our medical staff to be reasonable.

It is our hope that HCFA will address this issue soon and arrive at some alternative to the current payment system.

If you would care to call me around the middle part of September, perhaps I will have some more information regarding this issue. I can be reached at (612) 456-8265 for any questions you may have.

Sincerely,

/s/ Linda Mack
Linda Mack
Assistant to the Medical Director
Government Program

LM:ls

MEDICARE

Part B Office – P.O. Box 64357 –St. Paul, Minnesota 55164 – (612) 456-5070 – 1-800-392-0343

August 29, 1990

Ms. Mary Stotko
Business Office
St. Cloud Hospital
1406 6th Avenue North
St. Cloud, MN 56303

Dear Ms. Stotko:

It was a pleasure meeting with you and your coworkers on August 1, 1990.

There were two issues discussed. The first was our denial of CRNA services when performed with an anesthesiologist. This involved procedure codes 00562, 00210, 00216, 00218, 00220, 00222, 00350, 00770 and 00880. As we discussed during the meeting, I requested and received a report which lists the denied claims for services between January 1, 1989, and July 30, 1990. Some of the claims had been previously adjusted and paid. The remaining claims will complete processing in the near future. I have also notified the claims department management of this problem.

The second issue was the situation with about 250 claims that are billed with only charges for time and no charge for the base units. To my knowledge, there isn't anything we can do about that situation. You would have to identify the claims, recalculate your charges, and request a review of the claims. It is quite possible that even though your charge is not as high as you feel it should be, our allowance would not be affected by a higher charge since our payment calculation includes both time and base units.

Mary, I thought I had complete [sic] the follow-up work from our meeting when I received your note and the claims that needed to be adjusted.

I have referred all the claims, except those enclosed, to Customer Service for adjustment. I am also investigating options we may have to prevent incorrectly denying these claims when we first process them. I'll keep you informed of any changes or progress.

If I may be of further assistance, please call me at (612) 456-8620.

Sincerely,

/s/ Linda Krecklau
Linda Krecklau
Professional Relations Representative

LK:cac
Enclosures

B. Anesthesiology Services

1. Procedure Codes and Modifiers

The CPT-4 procedure codes 00100-01999 are used to report anesthesia services. The following modifiers listed in the HCPCS manual must be used for anesthesia services.

AA – Physician personally performed

CJ – Two concurrent procedures, medically directed by physician

QO – Three concurrent procedures, medically directed by physician

OQ – Four concurrent procedures, medically directed by physician

AD – Medically supervised by a physician for more than four concurrent procedures

QX – CRNA with medical direction by a physician

QZ – CRNA without medical direction by a physician

NOTE: The AA modifier must be used to report the direction of residents in furnishing not more than two concurrent anesthesia services – attending physician relationship met.

Use an additional modifier for *informational purposes only* when monitored anesthesia care is given.

QS – Monitored anesthesiology care services

This modifier may be billed by a CRNA or a physician. Since this modifier is an informational modifier, it must have a pricing modifier billed with it for the services to be processed correctly.

2. General Guidelines

- The claim must show the Medicare Processing Number (MPIN) of the anesthesiologist.
- The claim must show the ICD-9 diagnosis code for services performed by anesthesiologists.
- For services performed on or after April 1, 1990, the actual time in minutes must be shown in field 24g of the HCFA-1500. The three-digit reporting system should be used.

Example:

20 Minutes	Report 020 minutes
1 hour, 33 minutes	Report 093 minutes
3 hours, 10 minutes	Report 190 minutes

[LOGO]

Blue Shield

of Minnesota

Inner Office Memo Copy To: MARY JANE SALEM. MEDICARE B DISTRIBUTION

To: BECKY TIMM

From: KATHY HENRY

Date: NOVEMBER 15, 1989

Subject: ANESTHESIOLOGIST AND ANESTHETIST INVOLVED IN SINGLE PROCEDURE

WHEN AN ANESTHESIOLOGIST AND AN ANESTHETIST ARE BOTH INVOLVED IN A SINGLE ANESTHESIA SERVICE, THE SERVICE IS CONSIDERED PERSONALLY PERFORMED BY THE ANESTHESIOLOGIST. NO SEPARATE PAYMENT IS ORDINARILY RECOGNIZED FOR THE ANESTHESIA SERVICE (SEE EXCEPTION BELOW); DENY THIS CHARGE USING ACTION CODE. KT.

WHERE AN ANESTHESIOLOGIST AND AN ANESTHETIST ARE BOTH INVOLVED IN ONE OF THE FOLLOWING PROCEDURES, THE ANESTHESIOLOGIST'S *AND* ANESTHETIST'S CHARGE MAY BOTH BE ALLOWED. THE ANESTHETIST'S CHARGE MUST BE KEYED WITH MODIFIER ZF. IF MODIFIER ZG IS SUBMITTED, CHANGE THE MODIFIER TO ZF.

CRANIOTOMY CODES – 00210, 00212, 00214, 00216, 00218, 00220 AND 00222

CAROTID ENDARTERECTOMY CODE – 00350

OPEN HEART SURGERY CODE – 00562

ABDOMINAL ANEURYSM CODES – 00770 AND 00880

MULTIPLE TRAUMA CASES –

YOU MAY RECOGNIZE A SEPARATE CRNA FEE SCHEDULE PAYMENT FOR PROCEDURES OTHER THAN THOSE LISTED ABOVE ONLY IF YOU RECEIVE DOCUMENTATION SHOWING THAT IT IS MEDICALLY NECESSARY FOR BOTH THE ANESTHESIOLOGIST AND THE ANESTHETIST TO BE INVOLVED. IF DOCUMENTATION IS ATTACHED, SEND CLAIM TO C01. THE REASONABLE CHARGE SPECIALIST (C01) WILL SEND THE CLAIM TO MEDICAL REVIEW, WHO DETERMINES IF BOTH THE CRNA/AA AND ANESTHESIOLOGIST SERVICES SHOULD BE ALLOWED IN THIS SITUATION.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

MINNESOTA ASSOCIATION OF NURSE ANESTHETISTS, GAYLE McKAY, LADONNA SCHWEER, JOHN OKONEK, BERNADINE OKONEK, ANNETTE ATCHISON, FRED BENJAMIN, BART BARRY, FAYE LEATHERMAN, SUE MILBACH, SANDRA HENSCHKE, JUDITH A. SCHMIDT and GARY HAGEN,

Plaintiffs,

v.

UNITY HOSPITAL, MERCY HOSPITAL, WILLIAM MACNALLY, ALLINA HEALTH SYSTEM CORP., MARK SPERRY, M.D., GARY BAGGESNTOSS, M.D., JOHN MURPHY, JAMES CUMMING, M.D., JOHN RYDBERG, M.D., MIDWEST ANESTHESIA, P.A., THELMA M. ALBAY, M.D., MINDA CASTILLEJOS, M.D., TERI HEIL, M.D., SANG HONG, M.D., TED JANOSSY, M.D., RAYMOND KLOEPPER II, M.D., JOHN MAGDSICK, M.D., THOMAS MAGGS, M.D., THOMAS POLLTA, M.D., JOHN ROSEBERG, M.D., JAI SUH, M.D., JEFFREY YUE, M.D., MARK EGGEN, M.D., METROPOLITAN ANESTHESIA NETWORK, ALLEN

Case No. 3-94-1446

TANK, THEODORE GRINDAL, ESQ., CRAIG JOHNSON, M.D., (both individually and in his capacity as President of the Minnesota Society of anesthesiologists), ST. CLOUD HOSPITAL, JOHN FROBENIUS, LINDA CHIMIELEWSKI, ANESTHESIA ASSOCIATES OF ST. CLOUD, LTD., GARY A. BOEKE, M.D., PHILIP F. BOYLE, M.D., L. MICHAEL ESPELAND, M.D., ALAN D. ESPELIEN, M.D., PAUL J. HALVERSON, M.D., LANSE C. LANG, M.D., A. WADE McMILLAN, M.D., WILLIAM H. RICE, M.D., ANNETTE E. ZWICK, M.D.,

Defendants.

Deposition of MARK SPERRY, M.D., taken before Jill Columbus, a Notary Public in and for the County of Hennepin, State of Minnesota, on Wednesday, the 15th day of May, 1996, commencing at approximately 9:45 o'clock in the morning, at 2510 Minnesota World Trade Center, 30 East Seventh Street, in the city of St. Paul, Minnesota.

* * *

[101] Travelers need to work out their differences and then once HCA and Travelers have worked out their differences of interpretation, then HCFA needs to make a decision about how to approach a problem in which one of their intermediaries has been informed to submit bills in a certain fashion and that wasn't consistent with what the HCFA home office did. And then once they've

worked out what those differences are, then I'm assuming we would be getting involved in that.

Q. All right, And you'll continue to bill the way you've been billing until somebody tells you differently?

A. . . . I'm going to continue to bill in the method that I've been advised by Travelers to bill until they advise me to submit the bill differently.

Q. Okay. Now you say you had a conversation in 1991 with somebody at Travelers?

A. Yes.

Q. Is that the first conversation that you recall about this issue with anybody at Travelers?

A. Yes.

Q. Tell me everything that he said to you and everything that you said to him as best as you recall it.

A. Well, I called up Mr. Esterley and I said that we've been advised by Mercy and Unity Hospital that there had been an audit and that audit denied charges from Mercy [102] and Unity – or that HCFA, that Travelers had denied charges from Mercy and Unity for one-to-one bills. And I described to Mr. Esterley how we practiced anesthesia. And I said that on one-to-one cases typically the hospital has CRNAs, we supervise those CRNAs and if we have one case going and there are no other concurrent cases going, how would he like me to submit those bills. Mr. Esterley told me that we should submit those bills using the AA modifier as a one-to-one case. His impression was that as long as we were not performing any other income generating service and that was our sole responsible case, we could submit that bill using the AA modifier

or as a one-to-one case. I through our conversations felt fairly comfortable that he knew that we were supervising CRNAs. I said that – I know that we discussed the issue that in our situation since the CRNAs were hospital employees it would become an awkward environment for us if I were to tell a CRNA you go sit in the lounge because this is a Medicare case and it's a one-to-one. He indicated to me that he could understand that position and that occurrence. And I suggested to him that this was a problem for us because the hospital was unhappy that they were having charges be denied. I suggested some alternatives. I said what about if we just submit all of our bills as concurrent, one-to-one. [103] That way the hospital would be getting paid for CRNA services, we would be getting reimbursed less money than if we were using the AA modifier but the net balance would be that the hospital was happy and the CRNAs were happy. As far as I was concerned and I think the rest of my group was concerned, the Travelers or the Medicare reimbursement for anesthesia services is relatively low and if it's a little bit lower it's not going to be that big of deal to us economically. He told me that if I were to submit a bill in that fashion I would be submitting a bill fraudulently because in fact my concurrency was not one-to-two, it was one-to-one. Then I also suggested the option of what about if I just don't submit a bill but I provide the anesthesia services. I won't submit a bill, the hospital then can submit their bill, there won't be an AA modifier from the anesthesiologist and the hospital would be paid for CRNA services. He told me that that would also be fraudulent because I would then be in effect in those latter two instances colluding with another medical entity so that they might receive monies and I – and that in his opinion that wasn't an appropriate action.

Q. Let me just stop you for a second. He told you that if you didn't submit bills, that that would be fraudulent because you would be colluding with the people that were [104] submitting the bills?

A. Right. I would be entering into some sort of a collusive arrangement where I would be providing a service but not billing so that another entity could bill.

Q. Okay. What else did he say?

A. I asked him if he would be willing to write me a letter. And he told me at that time that he would not be willing to write me a letter because that might be interpreted as a ruling from HCFA and he wasn't in a position to do that.

Q. So you understand that HCFA was the entity that had to provide rulings? Correct? He couldn't provide rulings?

A. Well, I think that's a mischaracterization. My understanding was that HCFA promulgated rulings, however, Travelers position was one of making an interpretation of the HCFA rules and regulations and applying them to a practical situation in which I am a party – in a practical anesthesia practice environment.

Q. By the way, you understand, do you not, that the bills that you submit to Travelers do not anywhere on them say medical direction of a single procedure? Do you understand that?

A. I believe that that might be correct. I'm not 100 percent certain

* * *